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*Understanding the Sexual Health Information Needs  
and Preferences of “Hard to Reach” Young People*

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A thesis submitted to Middlesex University in partial fulfilment of the  
requirements for degree of  
Doctorate of Philosophy

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## Abstract

**Background-** The purpose of this research was to understand the needs and preferences of young people who are labelled as “hard to reach” when it comes to the delivery of sexual health information. Up to this point, most research has taken the form of needs’ assessment, or service or outcome evaluations; thus it has had a predominantly practical, problem-solution focus. This qualitative study was theoretically informed by and focused on achieving a deeper level of understanding by exploring the phenomenon under investigation rather than reporting on existing situations and offering solutions to problems. Critical appraisal of current literature and current policy as well as triangulation of the data was used to challenge the labelling of young people as “hard to reach”.

**Method-** Semi-structured interviews were carried out in London with 23 young people from both genders who were ‘Not in Education, Employment or Training’, (NEET), peer educators (11) and professionals (15) who were responsible for the design and delivery of the information to NEET young people.

**Main Findings:** Thematic analysis of the data indicated that young people’s perceived needs for sexual health information were not in accordance with the perceptions of the providers. Even peer educators who were young people themselves and were from the same socioeconomic backgrounds seemed to have different views from young people in the category of ‘hard to reach’. This could be because of their social mobilization through becoming peer educators thus distancing them from the group they are serving. Their perceptions were more similar to those of professionals than young people. Young people’s descriptions of their needs regarding sexual health information fell into three main categories: Need for a Significant Other, Need for Help and Need for Information. These three categories acted as umbrella terms for six sub themes that emerged from the data. The sub-themes describe young people’s attitudes towards reaching out to obtain information and how they treat the information that is presented to them. Three of the sub-themes shed light on factors that could influence a young person’s acquisition of sexual health information, namely, trust, reliability and comfort. The other three sub-themes highlight challenges for the provision of information; these were quality and quantity of the information, helpfulness of the information source and accessibility.

This study sheds light on a marginalized group of young people who have not been studied before in such depth; it challenges the use of the label ‘hard to reach’ and offers a critique of current policy approaches. The thesis concludes with some recommendations for research, policy and practice with the aim of developing a more responsive service for young people.

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Albert Einstein once said: “*the significant problems we face cannot be solved at the same level of thinking we were at when we created them.*”

## TABLE OF CONTENTS

<b>CHAPTER 1: INTRODUCTION</b>	<b>9</b>
1.1. THE PURPOSE AND BACKGROUND OF THIS RESEARCH:	9
1.2. AIM AND MAIN RESEARCH QUESTIONS	10
1.2.1. Research questions	11
1.3. BRIEF DESCRIPTION OF CHAPTERS	12
1.3.1. Background and Policy Context	12
1.3.2. Literature Review	12
1.3.3. Methodology and Methods	12
1.3.4. Findings	13
1.3.5. Recommendations	13
1.3.6. Conclusion	14
<b>CHAPTER 2: BACKGROUND AND POLICY CONTEXT</b>	<b>15</b>
2.1. AN OVERVIEW OF POLICY CONTEXT	15
2.2. DEFINITION OF SEXUAL HEALTH IN THE GLOBAL CONTEXT	17
2.3. SEXUAL HEALTH IN THE CONTEXT OF GREAT BRITAIN	20
2. 4. NEW LABOUR GOVERNMENT’S RESPONSE	21
2.4.1. Problematisation of adolescents sexual health	21
2.4.2. Health behaviour and the case for the provision of sexual health information in UK	27
2. 4.3. Creation of a National Sexual Health strategy and the outcomes-oriented model of sexual health	32
2.4.4. The Outcomes of the Sexual Health Strategy	35
2.4.5. Critiques of New Labour Government’s sexual health strategies	39
2.5. YOUNG PEOPLE AND SOCIAL EXCLUSION	41
2.6. CONCLUDING REMARKS	44
<b>CHAPTER 3: LITERATURE REVIEW</b>	<b>45</b>
3.1 SEARCH STRATEGY	45
3.2. SEXUAL HEALTH INFORMATION NEEDS AND PREFERENCES OF HARD TO REACH YOUNG PEOPLE: PERSPECTIVES IN RESEARCH	47
3.2.1. The problematisation of young people’s sexual health	51
3.3. THE CONSTRUCTION OF ADOLESCENCE IN THE LITERATURE	52
3.3.1 Young people and (sexual) risk	56
3.3.2 Social exclusion and the construct of “hard to reach” young people	59
3.3.3. The construct of “hard to reach” young people	62
3.4. SEXUAL HEALTH NEEDS OF SOCIALLY EXCLUDED YOUNG PEOPLE	67
3.4.1. Asylum seekers and refugee groups	67
3.4.2. Black and Minority Ethnic (BME) groups	69
3.4.3. Homeless and runaway young people	70
3.4.4. Sexual minority groups	71
3.5. THE ROLE OF PERCEPTION IN INFLUENCING SEXUAL HEALTH INFORMATION NEEDS	72
3.6. SEXUAL HEALTH INFORMATION PROVISION INITIATIVES FOR YOUNG PEOPLE OUTSIDE SCHOOLS	76
3.6.1. Media	76
3.6.2. Outreach work	79
3.6.3. Peer Educators (PE)	80
3.6.4. One-Stop Shops	83
3.6.5. Taking every opportunity to teach young people about sexual health	84
3.7. CONCLUDING REMARKS	84

3. 8. IMPLICATIONS OF LITERATURE REVIEW FOR THIS RESEARCH AND THE DATA COLLECTION .....	86
<b>CHAPTER 4: METHODOLOGY AND METHOD .....</b>	<b>89</b>
4.1. THE CHOICE OF QUALITATIVE RESEARCH METHOD AND THEORETICAL UNDERPINNINGS FOR THIS RESEARCH .....	89
4.2. DATA COLLECTION/MANAGEMENT AND ANALYSIS .....	91
4.3. DATA SATURATION .....	92
4.4. ROLE OF RESEARCHER IN IPA .....	92
4.5. PROCESS AND PROTOCOL .....	93
4.5.1. <i>Development of the interview schedules</i> .....	93
4.5.2. <i>Recruitment and Data Collection</i> .....	98
4.5.2.1. Recruitment process .....	99
4.5.2.1.1. Young people .....	103
4.5.2.1.2. Peer educators and Professionals .....	106
4.6. INTERVIEW PROCESS .....	106
4.6.1. <i>Group One: "Hard to reach" young people</i> .....	106
4.6.1.1. Characteristics of the sample: Young people .....	111
4.6.2. <i>Group Two: Peer Educators</i> .....	114
4.6.2.1. Characteristics of the sample: Peer Educators .....	115
4.6.3. <i>Group Three: Professionals</i> .....	116
4.6.3.1. Characteristics of the sample: Professionals .....	118
4.7. TRANSCRIPTION .....	118
4.8. DATA ANALYSIS .....	119
4.8.1. <i>Thematic Analysis</i> .....	119
4.8.2. <i>Triangulation of the Data</i> .....	119
4.8.3. <i>Analysis of the data step by step</i> .....	120
4.9. ADVANTAGES AND LIMITATIONS OF THE CHOSEN METHODOLOGY .....	122
4.10. CREDIBILITY .....	124
4.11. TRANSFERABILITY .....	125
4.12. DEPENDABILITY .....	125
4.13. CONFIRMABILITY .....	125
4.14. CONCLUSION .....	126
4.15. ETHICAL CONSIDERATIONS .....	127
4.15.1. <i>Working with "hard to reach" young people</i> .....	127
4.15.2. <i>Ethics committee approvals</i> .....	128
4.15.3. <i>Risk management</i> .....	129
<b>CHAPTER 5- FINDINGS: DESCRIPTIVE AND INTERPRETIVE THEMES .....</b>	<b>131</b>
5.1. INTRODUCTION .....	131
5.2. EXTRACTING THE MAIN THEMES FROM THE DATA .....	131
5.3. MAIN THEMES EMERGING FROM THE DESCRIPTIVE ANALYSIS OF THE DATA .....	135
5.3.1. <i>Need for Information</i> .....	137
5.3.1.1. Formal sources of sexual health information .....	137
5.3.1.2. Informal sources of sexual health information .....	140
5.3.1.3. Content .....	146
5.3.1.4. Lack of perceived need for information .....	154
5.3.1.5. Competing needs .....	157
5.3.1.6. Other factors that impact on the perception of need for information .....	159
5.3.2. <i>Need for Help</i> .....	164
5.3.2.1. Young people seek out help rather than information .....	164
5.3.2.2. Professionals' needs for help .....	165
5.3.2.3. Young people's needs for help: expressed and implied .....	170
5.3.2.4. Help planning for the future .....	173
5.3.3. <i>Need for Significant Other</i> .....	176

5.3.3.1. Segmented networks of support .....	177
5.3.3.2. Significant others and the construct of “hard to reach” .....	188
5.4. CONCLUDING REMARKS .....	189
<b>CHAPTER 6: SEXUAL HEALTH INFORMATION ACQUISITION: TRUST, RELIABILITY, AND COMFORT .....</b>	<b>190</b>
6.1. TRUST .....	191
6.1.1. ‘The System’ .....	191
6.1.2. The importance of shared values .....	195
6.1.3. Trust as it relates to experience .....	196
6.1.4. Confidentiality .....	198
6.2. RELIABILITY .....	203
6.2.1. Evaluating reliability .....	204
6.2.2. Professionals as reliable sources of information .....	209
6.2.3. Bridging the gap between reliability and trust .....	210
6.2.4. Professionals’ views of their own reliability .....	212
6.3. COMFORT .....	213
6.3.1. Gender, culture, and religion .....	213
6.3.2. Personal inhibitions to accessing services .....	218
6.3.3. Sexual health as a taboo subject .....	220
6.3.4. Establishing comfort: the professionals’ view .....	222
6.3.5. Young people’s perceptions of comfort .....	225
6.4. CONCLUDING REMARKS .....	227
<b>CHAPTER 7: PROVISION OF SEXUAL HEALTH INFORMATION: ACCESSIBILITY, HELPFULNESS, QUANTITY/QUALITY .....</b>	<b>229</b>
7.1. ACCESSIBILITY .....	229
7.1.1. Accessibility and the construct of “hard to reach” .....	230
7.1.2. Professionals’ views on who is “hard to reach” .....	232
7.1.3. Accessibility as it relates to availability .....	239
7.1.4. Media .....	243
7.2. HELPFULNESS .....	251
7.2.1. Helpfulness as it relates to outcome .....	251
7.2.2. Helpfulness and one-on-one SRE sessions .....	254
7.2.3. Wants vs needs: the importance of choice .....	255
7.2.4. Right place, right time .....	257
7.3. QUANTITY AND QUALITY OF THE SEXUAL HEALTH INFORMATION .....	260
7.3.1. Age as it relates to quantity of information .....	260
7.3.2. Need for formal assessment of programs .....	266
7.3.3. Quantity and quality of information as they relate to considerations of time .....	269
7.4. CONCLUSION .....	272
<b>CHAPTER 8: DISCUSSION AND RECOMMENDATIONS .....</b>	<b>275</b>
8.1. DIFFERENT PERCEPTIONS OF THE SAME PHENOMENON .....	275
8.2. RECOMMENDATIONS .....	277
8.3. Development and training .....	277
8.4. Development of effective outcome measurement methods .....	279
8.5. Raising levels of awareness .....	281
8.6. Developing a wide variety of materials and resources .....	282
<b>CHAPTER 9: CONCLUSION .....</b>	<b>284</b>
<b>REFERENCES .....</b>	<b>316</b>



**Appendices List:**

Appendix 1- Demographic Form (young people and peer educators)

Appendix 2- Interview cues and probing questions for three groups

Appendix 3 - Information Sheet

Appendix 4 -Consent Form

Appendix 5 - Demographic information of young people

Appendix 6 - Frequency of the most cited keywords and phrases in “hard to reach”  
young peoples’ interviews

Appendix 7 - Reflexivity: My role as a researcher

Appendix 8 - Sample Interview Transcription and analysis

# Chapter 1: Introduction

## ***1.1. The Purpose and Background of this Research:***

The purpose of this thesis is to further understand the needs and preferences of the group of young people who are labelled as “hard to reach” when it comes to the delivery of sexual health information. Up to this point, most of the research in this area has been funded by Governmental organisations and has taken the form of either needs assessment, service or outcome evaluation; thus it has had a practical, problem-solution focus. It follows that most of the existing literature is similarly concerned with the practical side of this topic: defining vulnerable groups, formulating the problem to be solved, accessing the target group, changing their behaviours and obtaining a desired outcome.

Following the works of other social researchers, this research will instead attempt to focus on a much deeper and more comprehensive level of understanding by exploring the construction of the phenomenon under investigation rather than reporting on the existing situation and offering solutions to solve the formulated problems. It will take a new angle by looking at the sexual health needs and preferences of “hard-to-reach” young people from three perspectives:

- 1) The young people themselves, referred to as “hard to reach” in this research<sup>1</sup>.

They are adolescents between the ages of 14 to 19 who are **Not** in mainstream

Education (schools), **E**mployment or **T**raining —also referred to as **NEET**. The

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<sup>1</sup> Throughout this research whenever there is a discussion of NEET young people the phrase “hard to reach” is used to indicate that the label itself is under question. However, when there is a discussion of policy documents or literature where they are referred to as socially excluded, then that label is retained in the discussion.

main inclusion criteria for being “hard to reach” in this research is that the individual has a history of truancy from school; he or she also must exhibit at least one of the risk factors for being labelled as socially excluded in the literature. These criteria for inclusion were taken from the literature and policy statements and will be discussed more fully in subsequent sections.

- 2) Peer Educators (PE). These are young people, mostly from the same socio-economic background as the first group, who are recruited and trained to act as bridges between ‘hard to reach’ young people and professionals.
- 3) The professionals. These are the sexual health professionals and other adults who are involved in the design and/or provision of sexual health information to young people outside the school settings.

## ***1.2. Aim and Main Research Questions***

The aim of this research is to deepen understanding of the scarcely explored area of needs and preferences for sexual health information of ‘hard to reach’ young people from the perspectives of the young people themselves, peer educators and professionals. In so doing, the research set out to explore the meaning young people bestowed on sexual health education in the light of their own experiences and perceptions of their current situations and needs.

### **1.2.1. Research questions**

The main question which this study set out to answer was ‘What, if any, are the differences in perceptions of sexual health information needs between ‘hard to reach’ young people, peer educators and professionals and what are young people’s own perceptions of their needs and preferences for sexual health education?’

However, it was necessary, first of all, to critically examine the concept of ‘hard to reach’ as used in policy and practice literature. This generated further research questions:

- Who is seen as a “hard to reach” young person when it comes to the delivery of sexual health information and what are the social constructs of such a categorisation?
- Do these young people see themselves in need of sexual health information and, if so, what is the reasoning behind their specific preferences?

Following that, the research questions were set to examine possible differences between the perceptions of the three groups (young people, peer educators, professionals) and to explore the implications for the delivery of sexual health education:

- Are young people’s views any different from the peer educators and professionals? If so, what informs this difference?
- How might we bridge the concept of “hard-to-reach” by accessing these young people to deliver sexual health information to them?

### **1.3. Brief Description of Chapters**

#### **1.3.1. Background and Policy Context**

Through a review of the relevant policy documents, this chapter will explore how the sexual health of young people became a socio-political issue in the United Kingdom. As part of this discussion, I will introduce the concept of ‘social constructionism’ (Berger and Luckmann, 1996) and show how this theoretical perspective can be used to shed light on the emergence and evolution of New Labour’s policy on young people’s sexual health and teenage pregnancy. This will be followed by a brief discussion of the statistics behind our current national health strategies.

#### **1.3.2. Literature Review**

This chapter will provide an overview of sexual health research and will introduce commonly accepted definitions of sexual health both in terms of the individual and in terms of the wider social context. Using a range of research and commentary papers, I will go on to critically discuss some possible reasons why those strategies came about and why they were less effective in producing the desired outcomes than was hoped at the outset.

#### **1.3.3. Methodology and Methods**

The methodology of this research was informed by the Interpretivist school of thought, sometimes hailed as the most appropriate methodology for exploring social phenomenon (Bryman, 2004, p. 13, 540). Interpretive Phenomenological Analysis (IPA) comes within this methodological tradition and has been adapted to inform the method of data collection and analysis of this research. IPA is recommended for explorative studies

around topics about which we do not know a great deal and for use with groups that are hard to recruit (Willing, 2001). The advantages and limitations of this choice are discussed in the methodology chapter in this research.

#### **1.3.4. Findings**

The findings chapters 4,5 and 6 will discuss the three areas of need that emerged in the descriptive analysis of the data: the *Need for Information*, the *Need for Help*, and the *Need for a Significant Other*. Further analysis of the data reveals six additional themes that relate to the needs and preferences of “hard to reach” young people. Describing these themes provides the groundwork for exploring the factors that facilitate or impede a young person’s ability to acquire information, perceive it as reliable, and be able to assimilate it into their thinking. The factors include *trust* towards the system which provides the information; the *reliability* of the provider and of the information (from young person’s perspective) and the level of *comfort* the young person feels in accessing the information, including feeling comfortable with the person who provides the information.

#### **1.3.5. Recommendations**

Providing sexual health information to namely hard to reach young people is a complicated task that requires participation on many levels, from the young people themselves to the outreach workers in the streets; from the curriculum designers to the Government agencies who make the policies geared toward helping this group. In this

chapter I will set forth some recommendations, based on this study, for action in the future.

### **1.3.6. Conclusion**

The main contribution of this work was the voice it gave to a group of young people who are labelled as “hard to reach” when it comes to the provision of sexual health information and services. The findings of this study indicate that improving the sexual health outcomes of vulnerable young people is more complicated than simply providing accurate sexual health information. Triangulation of the data showed the discrepancy that exists between the young people’s point of view and the views of adult professionals who are in charge of the design and delivery of this information to them. Even Peer educators who are young people themselves seemed not to identify with the group they serve. Recommendations from this research could help to expand our understanding of the needs and preferences of these young people, the contexts of their everyday life, their more general needs for survival and how we might bridge the gap between the adult world and their world to provide them with accurate and timely information when they need it. **The thesis also provides a critique of policy which may serve to perpetuate stereotypical responses linked to the labelling of some groups of young people as ‘hard to reach’.**

## **Chapter 2: Background and Policy Context**

### ***2.1. An overview of Policy Context***

Sexual health research has a long history which goes back to the years post World War II (Weston and Coleman, 2004), but it has undergone many changes since that time. Until the late 1980s, many social scientists' interest in sexual behaviour was restricted to the context of marriage. Malinowski (1992) and Mead (1949) are among the few anthropologists who regarded sexuality and the social control of sexual expression as legitimate domains of study. Sexual behaviour was also studied demographically, but only in terms of determinants of fertility (World Fertility Survey, WFS, 1970s).

This trend changed with the advent of the HIV pandemic in 1986 (Mann and Kay, 1991), which transformed research priorities. Discussions around sexual health became more of a public health issue (and later a political issue) that, if not addressed, could result in global disaster. This new sense of urgency was informed by international data indicating that in most developing countries the main route of infection was heterosexual intercourse; the strongest individual risk factor was the number of sexual partners. It was also reported that the majority of infections occurred among young people. Thus, in order to understand the spread of the disease, inform a public information campaign and evaluate interventions to check the spread of the epidemic, the focus of attention had to shift away from sexual health behaviour within marriage and towards sexual partnerships outside marriage (Ali and Cleland, 2006).

Very few studies of young people's sexual behaviour were carried out before 1990. Since then, in the shadow of the HIV pandemic, there has been a dramatic increase in the number of studies, the topics they have focused upon, and the areas in the world in



which they have been carried out. Efforts have been made to gain a clearer understanding of both the sorts of sexual activities in which young people are engaging as well as the factors that affect these activities in terms of safety and protection from *unintended* outcomes (Ingham, Aggleton, 2006, p 2). Originally, surveys were conducted to obtain an epidemiological sense of Knowledge, Attitude and Practice (KAP) — later amended to become Knowledge, Attitude, Practice and Behaviour (KAPB) — of certain population groups (Ali and Cleland, 2006, p 10). This was followed by qualitative work that provided insights into the social and cultural processes affecting various aspects of sexual activity, especially for harder to reach populations (such as people in rural areas, with lower levels of literacy, young people and so on) (Plummer, *et al.*, 2004; Gregson *et al.*, 2002, 2004).

These problem-focused initiatives were the motive behind most of the research around young people and their sexual attitudes and behaviours. As a result, some have argued that the “adults” in charge of funding and producing these data, including policy makers and researchers, fell into the trap of seeing young people’s sexuality *in general* as a negative phenomenon; later, other “adults” such as teachers, parents and carers, would come to view young people’s sexuality as problematic as well (Ingham and Mayhew, 2006, p 215). In addition, Ingham and Mayhew argue that the responsibilities and expectations linked to bigger players such as policy makers might cause them to interpret evidence selectively or uncritically when they feel pressured to produce positive outcomes (Ingham and Mayhew, 2006, p 210, 213-216).

Throughout this research it is emphasised that different points of view surrounding the existing evidence and/or its interpretation led to the current gap between

the presenting problem from the socio-political perspective and the reality of the situation as it might be seen by the young people themselves.

## **2.2. Definition of Sexual Health in the Global Context**

In 2002, the World Health Organization (WHO) provided the following working definition of sexual health:

*“Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”*

It is important to point out, however, that though the concept of sexual health certainly can and must be defined in terms of the individual, it also necessarily encompasses a larger social arena, particularly when one begins to discuss negatively defined sexual health outcomes as public health concerns.

Among the reports that put sexual health outcomes within the bigger socio-political context was the United Nation Children’s Fund’s (UNICEF) report. The publication of this report heralded a new phase in the discussions around the sexual health outcomes of young people, and the phenomenon of teenage pregnancy began to be understood as a negative sexual health outcome. This report, and the debates that it raised, caused a global shift towards focussing on young people and their sexual health outcomes.

The UNICEF report was undertaken in order to provide the most comprehensive survey to date on teenage birth rates in the industrialised world (UNICEF, 2001). In part, this was a response to concerns that had been raised by the heads of 28 industrialised countries regarding the increasing pregnancy rate among younger women. The authors suggest that for most of history teenage pregnancy was not seen as a problem; rather, it was something normal and desirable. Today, parents, politicians and physicians warn against it, and the Governments of most of the 28 countries mentioned in the report are trying to reduce it. The report went on to explain that teenage pregnancy and parenthood are known as a problem today because they are strongly associated with a range of disadvantages for the mother, for her child, for society in general, and for taxpayers in particular (p3). *“Reducing teenage births offers an opportunity to reduce the likelihood of poverty, and of its perpetuation from one generation to the next.”* (UNICEF, 2001, p3). The authors argue that the difficulty of the teenage pregnancy issue seems to be that the context for this phenomenon has changed so rapidly and radically that analysis and policy response can easily be outdated.

The report went on to interpret the World Health Organization definition of sexual health in light of the politico-social environment of the young person, explaining that:

*“. . . those countries with the highest teenage birth rates tend to be those that have marched far along the road from traditional values whilst doing little to prepare their young people for the new and different world in which they find themselves”* (UNICEF, 2001, p 13).

The UNICEF report makes the point that young people need to be better prepared to face this new world, challenged as they are by rapidly changing sexual norms and their consequences on one hand and increasing social opportunities for self actualisation and education on the other. In this light, it was emphasised that the sexual health of young people (and their sexual health outcomes) is a social issue as well as an individual one. Becoming a teenage parent, especially for young women, was added to the list of negative sexual health outcomes to be tackled in the global context.

This was the first large scale report which put emphasis on teenage pregnancy and its “somewhat complicated health and socio-political” aspects more than any other sexual health outcomes, including Sexually Transmitted Infections (STIs) and HIV/AIDS which were the focus previously. One cannot ignore the fact that although UN agencies aim to be objective in their development of evidence and protocols, at least in theory, the fact that they are funded by the Governments and should work in alliance with those Governments could have an impact on what they highlight as the main area of concern.

Social researchers have attempted to shed some light on the phenomenon of *teenage* pregnancy by exploring the social construct of the change of attitude towards young peoples’ sexual health status, including the ways in which different sexual health outcomes are being viewed by the players in this context from policy makers to young people themselves. Their findings generally agreed with some of the concerns raised by Governments, such as teenage parenthood increasing the truancy or drop out rate from school or work, which in turn has a direct impact on social exclusion of that person (for example Social Exclusion Unit, 1999b and 2004; Bonell, *et al.*, 2003). They have also

added more interpretations of the situation. For example, it is presented that although less than a third of young people are sexually active by the time they are 16, half of those who are use no contraception the first time; in retrospect most young women wish they had waited; and for a significant group, sex is forced or unwanted (Brown *et al.*, 2001; Wood, *et al.*, 1998). Teenage parents are more likely than their peers to live in poverty and unemployment (Phoenix, 1996; Palmer, *et al.*, 2006). In the longer term, their daughters have a higher chance of becoming teenage mothers themselves (Social Exclusion Unit, 2004). Research with different groups of young women indicates that violence or economic reasons were the cause for some to engage in sexual activity or enter a sexual relationship. (Wilson and Klein, 2002; Heath, et al., 1999; Fitaw, et. al .2005; Afifi, et al., 2003; Cecil and Matson, 2006) Therefore, young people are in need of counselling and contraceptive services on top of the information they receive (Wilson and Klein, 2002; Brindis, et. al. 1998). These in-depth, conceptual explanations have added to our understanding of the context in which all these behaviours take place.

The above section has provided an overview of the trends in policy and research regarding the sexual health of young people in the global context. The formation of a more focused, problematic view of sexual health outcomes of young people in Great Britain follows.

### **2.3. Sexual Health in the Context of Great Britain**

In 2001, and again in 2007, the Health Protection Agency (HPA) announced that the UK was facing a sexual health crisis, with STI statistics indicating that the UK has the worst sexual health in Europe. According to the HPA report, the sexual health status of young

people seems to be worsening (HPA, 2007). The incidence of syphilis remained high, and there were increases in genital herpes and genital warts (HPA, 2007). Estimated HIV prevalence increased to 73,000, with up to a third of these remaining undiagnosed (HPA, 2007). The report also drew attention to the fact that between 1991 and 2001 the number of new episodes of STIs seen in Genitourinary Medicine (GUM) clinics doubled both genders. Rates of diagnosis among females aged 16 to 19 years increased by more than 15 per cent (Office of National Statistics (ONS), 2001).

Though one could argue that these statistics are misleading—rather than showing a deterioration in sexual health the higher diagnostic rates might be due to an increase in the availability of services or an increased comfort-level among young people in seeking out those services—they have nonetheless sounded an alarm for the HPA.

Several years prior to this announcement by the HPA, similar observations were made both nationally (Department of Health, 1998) and internationally (UNICEF, 2001) regarding teenage pregnancy rates, which have also come to be seen as part of the public health crisis. The UNICEF report on teenage pregnancy, mentioned above, noted that the United Kingdom had the highest teenage birth rate in Europe; with 31 births per 1000 young women aged 15 to 19.

## ***2. 4. New Labour Government's response***

### **2.4.1. Problematicization of adolescents sexual health**

The UNICEF report discussed above, together with additional research (Social Exclusion Unit, 2004; Department of Health/ Department for Education and Skills, 2004), informed the Government's perception of the sexual health of young people as a

serious problem to be addressed. They also contributed to the construct of a problem that was now becoming more than a health issue. Based on these interpretations of the data, the Government came to the conclusion that if it did not attend to these matters, actively intervening to lower rates of STI and pregnancy among young people, the long-term negative effects could be substantial both for the young people themselves and for the nation as a whole: young people's health can be compromised and affected; they might end up unemployed and dependent on benefits and social care; and most importantly they might become socially excluded and marginalised (Department for Education and Employment, 2000; Bynner and Parsons, 2002).

Over the years teenage pregnancy has been seen to rise above all other sexual health concerns as a major burden from a social policy point of view (Social Exclusion Unit, 1999a; Swan, *et al.*, 2003; Wiggins, *et al.*, 2007) because of its links to social exclusion and long-term dependence on society's resources (Social Exclusion Unit, 1999; Bonnell, *et al.*, 2003). The Government decided that in order to tackle this "problem" they needed to prioritise funds and services to include young people in preventative and treatment programs (Social Exclusion Unit 1999b). This heavy focus on, and problematisation of, *teenage* pregnancy in the literature and policy debates raises an important question regarding the significance of other potentially troubling sexual health outcomes such as STI rates, which can seem eclipsed by the focus on *teenage* pregnancy.

There is a body of literature which examines why and how a particular issue becomes policy relevant – i.e. is taken up at a particular point in time as a social concern that must be addressed through policy responses (Walt, 1996, p 36 and 180; Walt, 1994). In Britain, the sexual health outcomes of young people only became a socio-political

phenomenon after the Labour Government at the time recognised poor sexual health outcomes as a contributing factor in the life long social deprivation of a young person, as indicated in the reports by the Social Exclusion Unit (1999b) and UNICEF (2001). However, one cannot help but be puzzled as to why politicians in the UK chose to focus only on this facet of the UNICEF report rather than any of the other ideas presented. For example, in addition to its emphasis on lowering *teenage* pregnancy rates, the report also acknowledged that “... *this is a matter of both motivation and means... means-availability of contraception and education to enable informed and mutually respectful choices... motivation-... a stake in the future, a sense of hope, and an expectation of inclusion in an their society...*” (UNICEF, 2001; 25). This statement seems to put the responsibility on the shoulders of the people who are responsible for the socio-political context of young people’s lives, rather than on the young people themselves.

It has been argued that the socio-political structure of Britain contributes to the view of *teenage* pregnancy as problematic: where there are social policies and a system of benefit in place (from the website of Citizens Advice Bureau, retrieved on 02/10/08), any factor that leads to an increase in the number of financially dependent young people might be seen as daunting for the Government (Social Exclusion Unit, 1999a). However there are not enough comparison studies with other nations to draw a robust causal map here.

Since the publication of the Social Exclusion’s report on teenage pregnancy there have been ongoing debates in the media and elsewhere regarding whether or not the Government's welfare supports are acting as incentives, encouraging young people to become parents or refrain from looking for employment (Talking Point-BBC News, 5,



March, 2001; Kristin, *et al.*, 1995). Usually benefits go to people over the age of 18; however, according to the current policy, parents under 18 are also entitled to many of those benefits, which are not available to their peers who do not have children. (For more information please go to the website of Citizens Advice Bureau the young people section at [www.adviceguide.org.uk](http://www.adviceguide.org.uk)). From this perspective, teenage parenthood is constructed as a problem not only because of adverse social outcomes for the parent and child in question, but because it is expensive for the Government.

In 2002, Lawlor and Shaw (from epidemiology and social medicine backgrounds) published an article discussing the differences between risk that had been ‘manufactured’ by the policy makers and the reality of the risk involved around the concept of teenage parenthood. They advised health professionals and the general public not to worry too much about the claims that the rate of teenage pregnancy in Britain is ‘high’ and increasing in an alarming way. They stated that “...we believe that the selective reporting of international and time comparisons by policy makers results in a ‘manufactured risk’ and has more to do with moral panic than with public health” (Lawlor and Shaw, 2002). This point has also been argued prior to Lawlor and Shaw’s commentary elsewhere (Bullen, *et al.*, 2000). Bullen, *et al.*, (2000) based their claim on the fact that the international comparisons suggest that the rate is moderate and that the past six decades have seen a decline rather than a rise. Over the same three to six decades the number of adolescents having sex has increased greatly (Wellings and Kane, 1999) and the age at menarche has decreased (Whincup, *et al.*, 1982–1986). The fact that birth rates have not risen in a time when the at-risk population rose sharply suggests (again contrary to popular opinion) that teenagers are reasonably competent at preventing unwanted

pregnancies (Wellings and Kane, 1999). This was another attempt to question the notion of the problem that had to be solved from the Government's point of view.

The moral subtext of this debate should not go unmentioned. In his preface to the Teenage Pregnancy Report of the Social Exclusion Unit (1999b), Tony Blair explained the overall UK viewpoint that underlies the sexual health strategies that have been developed for young people who choose to be sexually active:

*"Let me make one point perfectly clear. I don't believe young people should have sex before they are 16. I have strong views on this. But I also know that no matter how much we might disapprove, some do. We shouldn't condone their actions. But we should be ready to help them avoid the very real risks that under-age sex brings". (Tony Blair, preface to Teenage Pregnancy report, Social Exclusion Unit, 1999b, p4)*

Mr. Blair made clear his own values regarding teenage pregnancy, and assumes himself to be representative of the general population, ". . . we disapprove . . . . We shouldn't condone their actions . . . we should be ready to help them."

The world in which many of today's teenagers are growing up is very different from the world that shaped the adolescence of most of today's policy makers. Social scientists have argued that changing family structures in Britain, with nearly 50% of marriages ending in divorce and a diversity of family forms (Williams, 2004), have clearly contributed to reducing the social stigma attached to unmarried motherhood. Live births outside marriage have risen dramatically from 8.2% in 1971 to 38.7% in 1999 (ONS, 2001). The social acceptance of unmarried teenage motherhood is particularly prevalent among British working class communities (Tabberer *et al.*, 2000; Lee *et al.*, 2004). In a qualitative study with fifteen young mothers, Aral (2005) suggested that

among some communities early childbearing is not only acceptable but is a social and cultural norm.

There is also a debate that young people themselves might not see the outcomes of their behaviours as problematic, unintended or even negative (Jewell, *et al.*, 2000; Woodward, 1995; Hoggart, *et al.* 2006). Young people also might not see teenage pregnancy as a risk, especially when they weigh the benefits of becoming a young parent against the social stigmas attached to it (Hoggart *et al.*, 2006; Swan, *et al.*, 2003; Jewell, *et al.*, 2000). It has even been argued that young parenthood might be the only positive opportunity for some young people (Phoenix, 1991; Hoggart, *et al.*, 2006; Heket and Hoggart, 2004), as becoming a parent could define an adult identity for a young person and develop motivations for going back to school or to work. Also, young parents could experience emotional and social bonds with their child, with other parents and later on with their child's school. In some cases, even the benefits a young single parent receives from the council could be regarded as a factor that alleviates poverty to some extent and creates opportunities for the young parent to become independent and supposedly finish the transition from childhood to adulthood (Duncan and Hoffman, 1990; Lundberg and Plotnick, 1990; Moor, *et al.*, 1995; Field, *et al.*, 1980).

These ideas, taken together, raise some interesting questions regarding the social construct of the “problem” of teenage pregnancy. They also highlight the gaps between current knowledge, policy and practice (Teenage Pregnancy Unit, 2002; Hosie, *et al.*, 2006; Wellings, *et al.*, 1995). Keys, Rosenthal and Pitts (2006) attribute these gaps to over problematisation of issues related to young people’s sexual status. They emphasise that it is a biased view to see all teenage parenthood as a problem. They argue that it is

misleading not to distinguish between wanted and unwanted pregnancies, or single and coupled young women, when discussing “teen pregnancy”, particularly when it is being cast as problematic. All teen pregnancies are not the same. The experience and likely outcome of an unplanned pregnancy for a 13-year-old living in poverty and without family support is very different than that of a 19-year-old living with a partner and enjoying a pregnancy for which they have planned (Keys, *et al.*, 2006, p66).

This multi-perspective picture of teenage parenthood drawn by social researchers is a vital piece to have in mind when discussing the reasons for young people’s use of contraception and their decisions regarding termination and parenthood. Though from a social policy perspective it is easy to see teenage parenthood as an undesirable sexual health outcome, the individual teenagers in question might disagree.

#### **2.4.2. Health behaviour and the case for the provision of sexual health information in UK**

In the early 1980s Mrs Victoria Gillick ran a campaign challenging the Department of Health and Social Security Guidelines (DHSS, 1974) which gave the right to doctors to prescribe contraceptives as they thought it was appropriate to their patients regardless of age. Mrs. Gillick, a mother of ten, sought a declaration that not only would such prescriptions encourage sex among minors, they also constituted treatment without consent, as medical consent for those under 16 years of age is vested in the parent. The debate revealed widespread anxieties about teenage sexuality (Hawkes, 1995), and particularly the view that easily available contraception and information encourages sexual promiscuity in young people by removing the controlling factor of risk from

sexual encounters. Although the House of Lords decided in favour of the DHSS in October 1985, these concerns continue to influence the policy debates.

The widespread acceptance within Government of the view that sex education should promote the family is possibly the most enduring outcome of this previous policy conflict. In their recommendations for guidelines on sex and relationship education, they developed an ambiguous framework which both acknowledged that there are “mutually supportive relationships outside marriage” while at the same time emphasising that “. . . pupils should be taught about nature and importance of marriage for family life and bringing up children” (DfEE, 2000, p4). Hoggart argues that this ambiguity and historical legacy contributed towards a situation in which young people may be poorly informed about sex and contraception even while the potentially controlling factor of the risk of pregnancy has greatly diminished (Hoggart, 2007, p 188-189).

Despite the lack of clarity in the guidelines regarding the content of the materials to be provided, programmes were nonetheless set to be designed and delivered. Schools began to offer sex and relationship education (SRE) as a part of the Personal Health and Social Education and Citizenship (PHSE) curriculum. What’s more, it was left to the school to decide both the amount of time that would be allotted to the topic and the details of the content they were going to offer to young people. Not surprisingly, not all the schools followed the plan and not all of them were successful in providing comprehensive sexuality education to their pupils (e.g. in Thomson, 1994; Buston, *et al.*, 2001). In a retrospective study interviewing young mothers, Wiggins and her colleagues found that most of these young people believed their sex and relationship education (both at school and at home) was insufficient and the content of the

information they received was not relevant to their needs (Wiggins, *et al.*,2007). This point has been supported in other research as well (Hoggart, et al. 2006).

It seems that the acquisition of knowledge at school is only a minor cause for reproductive and sexual health outcomes in adolescents; there are much bigger determinants and factors that influence reproductive and sexual health decision-making processes in young people (Social Exclusion UNIT, 2004; Ginsburg, *et al.*,1997; Allen *et al.*,2007). For example, a survey conducted on 13-14 year olds in South East England found that teenage pregnancy is strongly linked with social exclusion and disliking school and not necessarily with teenagers' sexual health knowledge or attendance rate for SRE sessions (Bonell *et al.*,2003).

In 2006, Marston and King conducted a systematic review of 268 empirical qualitative studies that identify factors that might influence the sexual behaviour of young people (Marston and King, 2006). Surprisingly, among seven factors that they extracted from the literature, there was not much emphasis on the provision of sexual health information when the issues were discussed. Instead it was discovered that the social context of the young person, and pressures from society, peers and partners, played a much bigger role in determining a young person's sexual behaviour.

This idea is corroborated in a report created for the U.S. National Institutes of Health which puts forward a theoretical model for describing the complex and multi-layered set of factors which influence individual health behaviours in general (Rimer and Glanz, 2005, p11). The *intrapersonal level* concerns individual characteristics that influence behaviour, such as knowledge, attitudes, beliefs, and personality traits. The *interpersonal level* includes the interpersonal processes of the individual's primary

groups, such as family, friends, and peers who might provide social identity, support and role definition. On the *community* level there are *institutional factors* such as rules, regulations, policies and informal structures which may constrain or promote recommended behaviours; *community factors* such as social networks and norms, which exist formally and informally among individuals, groups, and organisations; and *public policy factors* which include local, state and federal policies and laws that regulate or support health actions and practices for disease prevention, early detection, control, and management. Thus while being well informed is certainly an important element of health behaviour, it is only one among a long list.

Based on such studies, one might be inclined to disregard the importance of education and the provision of information and advice when it comes to the sexual health of young people. However, from a rights-based perspective it remains important (Girard, 2001; UN General Assembly on Adolescent Sexual and Reproductive Health and Rights, 2002; UNFPA, 2002). Young people might engage in risky sexual behaviours because of many cultural and social reasons, but they have the ‘right’ to have the knowledge about the possible consequences of their actions in order to make informed decisions about their lives. Also, one can argue that perceptions and attitudes are undoubtedly influenced by one’s knowledge and information (Smith, and Rosenthal, 1995; Swann, *et al.*, 2003). For example, if young people are well educated about concepts such as cleanliness (identified in Marston and King’s review), they may well re-think how they respond to pressures from their partners not to use condoms (Marston and King 2006).

Though there is a great deal of consensus regarding the importance of access to sexual health information for everyone, when it comes to providing appropriate and useful information directly to socially excluded young people the matter becomes complex. Following the report on teenage pregnancy by the Social Exclusion Unit (SEU, 1999b), research was conducted in the field to ascertain the most effective forms of education and services for “hard to reach” young people. The Government tried to make sense of the findings, and to develop appropriate services (Arai, 2003). For example, they put more funding into out-of-school and more non-conventional methods of sexuality education. However, one of the points that was made in criticising the sexuality education materials in general was that they were developed and designed for delivery at schools and therefore were not necessarily effective for young people who did not attend school and might have had different expectations of the educational material offered to them (e.g. Monk, 2001). Although some of the initiatives were successful others have been criticised for not prioritising a consideration of social deprivation and poor job prospects, which is suggested to be the main factor for the early initiation of sexual relationships and risk taking among more vulnerable young people (Family Policy Studies Centre (FPSC), 1999).

In a round table discussion with service providers at the Urban Exchange (June 2005) it was suggested that the best practice for creating sexual health educational materials for young people would involve groups of professionals from diverse disciplines working together in consultation with young people. In this round table it was also suggested that the reason we have failed to meet young people’s needs in this area is that we do not understand those needs very well (Urban Exchange, June 2005). These



ideas also were elaborated and supported in other research articles (Ingham and Kirkland, 1997; Robinson, 1999) and Governmental and international organisation's documents (the Office of Government Commerce (OGC) Successful Delivery Toolkit, 2005; Social Exclusion Unit, 1999a; Santelli, *et al.*, 2003), and play a central role in this research as well.

#### **2. 4.3. Creation of a National Sexual Health strategy and the outcomes-oriented model of sexual health**

The Labour Government under Tony Blair responded to the sexual health “crisis” identified in the late 1990s by creating a strategy that had a strong focus on sexual health outcomes. In 2001 the Department of Health published The National Strategy on Sexual Health and HIV (P5), which included this comprehensive and holistic model of sexual health:

*“Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.”*

Though this definition acknowledges the human rights aspect of sexual health, and highlights the dual physical-mental sides of sexual health, as most WHO-type definitions of sexual health do, it also puts heavy emphasis on the issue of access to sexual health information and services, particularly as that information relates to the prevention of pregnancy, illness or disease. In this definition the main goal of sexual health appears to be prevention of unintended outcomes. Later in this policy document the socio-political and mental side of sexual health and its significance as a human right issue becomes even

less prominent amid strong statements focused on contraception and safer sex with the stated objectives of family planning and reducing the burden of STIs and unintended pregnancies.

Careful readings of the words of Yvette Cooper (DoH, 2001, p2), Parliamentary Under Secretary of State for Public Health at the time, in the foreword of The National Strategy made the direction of this policy document even clearer:

*“The control of HIV in England through providing people with information about risks, open access to Genito-Urinary Medicine (GUM) clinics and measures such as needle exchange schemes have resulted in us having one of the lowest rates of HIV in Western Europe. The availability of a broad range of contraceptive methods provided free by the NHS has given many women and men the opportunity to plan their families..... Despite these advances, there can be no room for complacency, as there are serious challenges to be met. There are an increasing number of people living with HIV, the rates of sexually transmitted infections have increased significantly in recent years, and there is a high rate of unintended pregnancies.”*

The national health strategy makes the clear point that poor sexual health among young people can result in unintended pregnancies, abortions and poor educational, social and economic opportunities for teenage mothers (Department of Health, 2001). In a report published by the Department of Health (1999), which was shortly followed by the Social Exclusion Unit's report on Teenage Pregnancy (1999b), there was a similar discussion on the adverse consequences that teenage pregnancy can bring to the young person from financial, social and health points of view. The Social Exclusion Unit report went further to make a link between teenage pregnancy and risk of social exclusion, followed by suggestions to tackle this phenomenon. A target was set to halve the under-18 conception rate by 2010 from a 1998 baseline (Social Exclusion Unit, 1999b).

The Department of Health strategy, in conjunction with the Social Exclusion Unit's report on teenage pregnancy, has three main implications for young people in terms of their sexual health needs. First, teenagers need to be offered services, means, information and advice in regards to their reproductive decisions. (The policies seem to encourage postponement of first sexual encounters, contraceptive use in subsequent sexual encounters, and the use of emergency contraception or termination in the event of potential or actual pregnancy.) Second, that STIs and HIV/AIDS need to be prevented as effectively as possible by promoting condom use and safer sex practices. (This is not particular to young people and applies across all age groups.) And third, that young people should be educated and informed with an objective to reducing their "risky" behaviours (i.e. unsafe sex) and promoting healthier behaviour from a health outcomes perspective.

The National Strategy on Sexual Health and HIV (Department of Health, 2001) acknowledges that many people lack the information they want and need to make informed choices that will affect their sexual health. It emphasises that there is a clear relationship between sexual ill health, poverty and social exclusion. Based on this foundation the Government has allocated funding to educational means and services at schools, clinical settings and some other community service settings with the intention of improving sexual health outcomes of the population in general and young people in particular.

#### **2.4.4. The Outcomes of the Sexual Health Strategy**

Eight years into these strategies, the results were not as was expected. In 2007 the Health Protection Agency announced that the UK is still facing a sexual health crisis, based on increasing STI rates among young people. And rates of teenage pregnancy, though somewhat lower than in 1998, had not declined as much as had been anticipated (Health Protection Agency, 2007).

In 2006 the Teenage Pregnancy Unit, a cross-Government department located within the Department for Education and Skills which was created to implement the Social Exclusion Unit's report on teenage pregnancy, published a report acknowledging the challenges it faced while trying to achieve the targets it had set out for itself (Teenage Pregnancy Unit, 2006). It was discussed that though current interventions —such as sex education at schools, provision of services and advice at healthcare facilities, peer education and outreach programmes—do have some effect, the desired impact is far from the targets set (Teenage Pregnancy Unit, 2006). The Government also acknowledged that it has not been very successful in putting strategies and plans into place for reaching out to socially excluded young people, defined here as those who fall into the general category of NEET, and improving their outcomes (Department for Education and Skills, 2006).

Based on the latest available provisional data, Office for National Statistics and Teenage Pregnancy Unit (2009) also released an update on under-18 and under-16 conception and termination rates. The report showed an overall decline of 10.7 % in the under- 18 conception rate and a fall of 6.4 % in the under- 16s since 1998, the baseline year of the strategy. Within the overall decline there had been an increase in the number of pregnancies that ended with abortion. Though this indicated some progress, it also

demonstrated that the initial target of reducing teenage pregnancy by half is not likely to be met by 2010 (Table 1 and Table 2) and highlights the complexity of this 'problem' (Office for National Statistics and Teenage Pregnancy Unit, 2009).

**Table 1: Under 18 Conceptions for England: 1998-2007**

Year	Under-18 conceptions	Under-18 conception rate*	Percent leading to legal abortion
1998	41,089	46.6	42.4
1999	39,247	44.8	43.5
2000	38,699	43.6	44.8
2001	38,461	42.5	46.1
2002	39,350	42.7	45.8
2003	39,553	42.2	46.1
2004	39,593	41.6	46.0
2005	39,804	41.3	46.8
2006	39,170	40.6	48.8
2007	40,298	41.7	50.6

Source: Office for National Statistics, 2009

\*Per thousand females aged 15-17

**Table 2: Under-16 Conceptions for England, 1998-2007**

Year	Under-16 conceptions	Under-16 conception rate*	Percent leading to legal abortion
1998	7,855	8.8	52.9
1999	7,408	8.2	53.0
2000	7,620	8.3	54.5
2001	7,407	8.0	56.0
2002	7,395	7.9	55.7
2003	7,558	7.9	57.6
2004	7,181	7.5	57.6
2005	7,473	7.8	57.5
2006	7,330	7.7	60.2
2007	7,715	8.3	61.9

Source: Office for National Statistics, 2009

\*Per thousand females aged 13-15

The Teenage Pregnancy Independent Advisory Group (TPIAG), which monitors the implementation of the Government's teenage pregnancy strategy and advises ministers, published its 5th annual report on 16 July 2008 (Teenage Pregnancy Independent Advisory Group, accessed 18/July, 2008). The goals of this strategy remained more or less the same as the original goals: To halve the number of under-18 conceptions by 2010; to establish a firm downward trend in the rate of under-16 conceptions; and to increase the participation of young mothers aged 16-19 in education, employment and training in order to reduce the risk of long-term social exclusion, with a target of 60% participation by 2010. The report still put a heavy emphasis on teenage parenthood and announced that:

*“... the teenage pregnancy rate is now at its lowest for over 20 years and is falling in 89% of local authorities. Some areas are experiencing dramatic reductions in their rates. In a few areas teenage conception rates continue to rise, or are stubbornly high. It alleged that if all areas showed the same commitment and applied the same key factors to accelerate their progress that characterise the 25% most successful areas, the overall reductions in the rate would be 27% (double the current figure of 13.3%) and on track to meet the 2010 target.” ”(p3)*

Despite this positive update, the report acknowledged that the teenage pregnancy rate in England is still one of the highest in Western Europe. Nonetheless it confidently claimed that, based on the lessons learnt since the first report and the strategies that emerged (Social Exclusion Unit, 1999b, Department of Health, 2001), it is clear what should be done to meet the 2010 goals.

### *A problem solving approach*

As one can see, all these reports share a common focus: finding the gap between the policies and strategies that were designed in late 1990s and their implementation. This problem-solution approach, and the rarity of relevant research involving the groups with the least access to sexual health services and information who are assumed to be at the highest risk for what is known as “poor sexual health”, may have been among the factors preventing policy makers and service providers from seeing the bigger picture. It also raises the question of whether or not the targeted groups see themselves as being in need of those services and information.

In 2009, at the time of this writing, the new Labour Government under Gordon Brown continues to refer to the disappointing teenage pregnancy statistics recently released by the National Audit Office. Based on these statistics, it has been suggested that the Government should pledge an additional £20.5m to bolster the delivery of the long-term Teenage Pregnancy Strategy and to address inadequate support and access to contraception for teenagers. The new package of measures includes:

- £7m for a new 'contraceptive choices' media campaign to raise awareness of the different options available to young people
- £10m for local health services to ensure contraception is available in the right places at the right time
- £1m to support Further Education (FE) colleges to develop and expand on-site contraception and sexual health services

As is evident, these sexual health policies are still heavily weighted towards preventing teenage pregnancy above all other sexual health issues that young people might face. It seems this new Government still is not prepared to look at the definition of the problem, but is instead pushing to implement strategies whose design was based on the problem as

it was formulated in the late 1990s. None of the discourse, as yet, addresses the crucial question of whether or not young people perceive themselves to be in need of the information and services the Government is trying to provide. The need for a new approach to the “problem” of *teenage* sexual health, such as that taken by this research, is all the more urgent.

#### **2.4.5. Critiques of New Labour Government’s sexual health strategies**

There are several angles from which one might approach the subject of the effectiveness of the National Strategy for Sexual Health and HIV and the Teenage Pregnancy Unit, particularly as they relate to young people who are labelled as “hard to reach” in the relevant literature.

Some argue that the current situation is the result of unavailability of efficient services to address young people’s sexual health needs, and that the UK still does not have an efficient policy to allocate enough funding to target these problems (Mason, 2005; Davey, 2005).

Others see it as a problem of access. They argue that there *is* an efficient policy in place, and there are enough resources, however young people might not have access to them for different reasons such as lack of awareness or cultural, language, disability, or social inhibitions and exclusions (McClean and Reid, 1997; Anderson and Kitchin, 2000).

Still others see the problem in the focus of the research and the need to move beyond simple models of health behaviour in order to explore more fully the dynamics associated with the timing of early sexual activity, as well as the factors associated with



effective contraceptive use (Ingham and Zessen 1997; Ingham, 1994). Efforts and explanations that are based on simple concepts such as lack of knowledge or irresponsibility miss the complex nature of early, risky, and other types of sexual activity. Obviously, lacking knowledge about contraception plays a role in non-use, but many other situational and contextual factors also play a significant role in determining when and how behaviour occurs. According to research conducted in Australia, the United Kingdom and the United States, some of those other issues include the availability of contraception (Stone and Ingham, 2002); pressure from a partner not to use a method (Dickson, *et al.*, 1998); the need to feel wanted; the desire to have a child; the ability to communicate effectively (Coleman and Ingham, 1998; Hillier, *et al.*, 1998; Shoop and Davidson, 1994; Lear, 1995); the influence of alcohol or drugs (Whibeck, *et al.*, 1999; MacDonald, *et al.*, 2000); and the influence of passion, trust, love and commitment (Aggleton, *et al.*, 1998).

Young people's sexual behaviour does not occur in isolation from wider social and structural influences. For example, data from the 1990 National Survey of Sexual Attitudes and Lifestyles (Macedowall *et al.*, 2006) indicate that children of divorced parents first have sex at a significantly younger age than those whose parents are still married (Kiernan and Hobcraft, 1997). Models of social development and problem behaviour have further identified factors that predict young people's behaviours, such as sexual risk-taking (Armitage and Conner, 2000; Rutter, *et al.*, 1997; Maughan and McCarthy, 1997). In a review by Stone and Ingham (2002) which drew from these models, it was suggested that young people who show commitment to social attachments and to conventional values, activities and institutions are less likely than others to engage

in antisocial behaviour and activities, including self-destructive behaviours such as engaging in risky sexual behaviours. Several studies have shown the impact of family relationships and bonds on teenagers' future sexual behaviour, including the supportiveness of the family environment, the extent of parental monitoring and intergenerational communication (e.g. Gillmor et al.1992).

Finally, there are those who approach the “problem” of the sexual health crisis by questioning the view that the situation is problematic in the first place. (Jewell, *et al.*,2000; Woodward, 1995; Hoggart, et al. 2006). People who raised this debate believe that while the Government might see (or choose to see) the teenage sexual health situation as problematic, particularly the issue of teenage parenthood, the young people themselves might not agree. Therefore problems around policy, resource availability and accessibility can assume a lower priority.

## **2.5. Young people and social exclusion**

Social exclusion entered UK policy discourse in particular in 1998 when the then New Labour Government established the interdepartmental Social Exclusion Unit (SEU) with an agenda to tackle social exclusion in high-risk groups (Social Exclusion Unit, 1999a).

Madanipour has defined social exclusion as a ‘multidimensional process’ in which various forms of exclusion—such as participation in decision-making and political processes, access to employment and material resources, and integration into common cultural resources—each has a role (Madanipour *et al.*,1998, p22). The Social Exclusion Unit website has provided a simpler definition, describing it as a combination of several problems such as unemployment, discrimination, poor skills, low income, poor housing, high crime, ill health and family breakdown. It adds that though social exclusion is not

bound to any specific age group, when it happens in young people the effects become much more significant (Social Exclusion Unit, 2005; Acheson, 1998).

In its 1999 report, the SEU emphasised the connection between social exclusion and teenage pregnancy. It linked primary social exclusion (e.g. the mother belonging to a socially excluded group primarily) with further social exclusion (the mother for different reasons being pushed towards social exclusion because of becoming a young mother). With this connection in mind, the Government aimed for better sex education, better screening for infections and significant reductions in teenage pregnancy and parenthood. It also aimed to reduce what was discussed as the *root cause* of the problem, i.e. the number of young people not in education, employment and training (Social Exclusion Unit, 1999a; Department of Health, 1998).

However, though this group remains a primary target in terms of national health strategies, there is not much data on how these young people perceive their own social status and sexual behaviour, an oversight that is not insignificant. Social researchers acknowledge that there is a dearth of understanding about the sexual health information needs and preferences of young people who were socially excluded and who were the primary target of these strategies (Wellings, *et al.*, 1995; Social Exclusion Unit, 2004). On a purely practical level, the group assumed to be at the highest risk have been mostly left out of the research. Given this situation, perhaps we need to change the nature of the questions we have been asking about the efficacy of our public health strategies. Apart from questions about the practicality of putting in place these strategies, one wonders where the strategies and the actions taken were on solid foundations to begin with? Who designed them and from what perspective?

For example, when it came to reducing the rate of STIs, the National Strategy for Sexual Health and HIV failed to identify a separate strategy that would recognize unique needs of the young and/or hard to reach. What's more, though this document was produced in consultation with professionals and service users, it does not necessarily mean that these groups could present the opinion of the whole population they were representing. It therefore seems likely that the so-called "hard to reach" group probably did not have a voice. These restrictions could explain some of the shortcomings of the current services and information addressed to young people.

This lack of first-hand knowledge of the sexual health information needs of young people has resulted in a narrow view in public health policy strategies. For instance, among the strategies presented by the Teen Pregnancy Independent Advisory Group recommendations of 2006 is one that aims to identify and support the young people at greatest risk of teenage pregnancy through effective targeted interventions. Yet in the strategy document itself one can see that the responsibility is assigned to the *providers* to reach out to these specific groups and provide the services or information the *providers* perceive these groups are in need of to prevent them from becoming teenage parents or having poor sexual health outcomes. It is easy to see how we might be left with a worst-case scenario in which providers are making huge efforts to provide contraception to people who do not necessarily want it, and information and services which might be seen as largely irrelevant to the lives of those being served.

## **2.6. Concluding remarks**

This chapter was an overview of the policy context which surrounds the sexual health of young people. It attempted to give an overview of the global perspective towards this phenomenon and narrowed it down to the context of Britain. It also gave an understanding of how the sexual health of young people had become a political issue above and beyond a social concern for different governments. Overall, it has highlighted a gap between policy makers and their perspective and young people's perspective of their situation due to each groups' socio-political context and priorities.

## **Chapter 3: Literature Review**

### **Introduction**

This research was informed by a variety of theoretical concepts to cover its various levels. This chapter will begin with a discussion of the multidisciplinary nature of studying this subject, including the influences that can affect research outcomes. This will be followed by an overview of psychological and social views of adolescence in the existing literature. It will then set out to explore the social construct of “hard to reach” young people as it relates to social exclusion and the concept of risk. It will go on to review the various subgroups of young people who are socially excluded and point out some of the significant social factors which influence their sexual health information needs and preferences. Finally, it will review some recent sexual health information provision initiatives aimed at “hard to reach” young people.

### **3.1 Search Strategy**

This research drew on published material in English between 1998 to 2009 on the subject of sexual health, young people and sexual health information. One might argue that there is a long history of social policy and health strategies related to sexual health of the nation in Britain after the World War II. However, this research was about the sexual health of young people, an issue which increased considerably as a matter of social policy attention and concern in the late 1990s. As the focus of this research is young people and their sexual health information needs, therefore a special attempt was made to identify the literature related to this group. The literature is drawn from different disciplines

to give a more holistic overview of the phenomenon under investigation since it is a complex issue which has been studied from different disciplinary perspectives.

All the main data bases were used to identify appropriate studies and policy documents; these included ERIC (Educational Research Information Center)), Pubmed, SSRN (Social Science Research Network), PsychInfo, HaPI (Health and Psychosocial Instruments), Social Policy and Practice search engine. Main keywords used in searching included: sex education, sex\* information and marginalized teenagers/adolescents, young people, young parents, out reach services, health busses, preference in education and sexual health. In addition, government fact sheets, protocols, reports and policy statements were identified from government web sites and other sources.

A more focused search was also carried out on the work of scholars in the field such as Roger Ingham, Peter Aggleton, Kaye Wellings and Nicole Stone. Reference lists in their works were a source of referral to new sources as well.

Libraries that offered the most complete sources on the topic include: London School of Hygiene and Tropical Medicine and Institute of Education.

I also gathered local and national information about existing services and grey literature from prominent researchers in the field (e.g. Peter Aggleton, Roger Ingham, Nicole Stone, Kay Willings) and local authorities. The literature review was ongoing and I added new studies and policy documents as they appeared throughout the course of my work.

Most recent advances in the field are reported in this final version of the thesis where necessary (for example the report by Sr.Mc Donald in 2009).

### **3.2. Sexual Health Information Needs and Preferences of Hard to Reach Young People: Perspectives in research**

Understanding the context of sexual health provision for young people is a complex task which has attracted the attention of researchers from a variety of disciplines including health, education, psychology, social care and politics (e.g. Wiggins, *et al.*, 2007; Stephenson, *et al.*, 2004; Rankin and Regan, 2004; Alcock, *et al.*, 2003; Ajzen and Maden, 1986). It is related to education in that it is about delivering messages and transferring knowledge to people with the intention of informing them, shaping their attitudes and beliefs, changing their behaviour and improving their sexual health outcomes (Aggleton and Campbell, 2000). It is within the remit of psychology as it addresses the individual's ability to perceive information and the capacity of his or her mind to evaluate and absorb what is relevant (Bauman, *et al.*, 1991; Speizer, *et. al.*, 2003; Borzekowski and Rickert, 2007). It is related to health because sexually transmitted infections (and, according to evidence presented in research and policy documents, teenage pregnancy) have direct implications on one's health status and outcomes, therefore preventative strategies, management and treatment options become involved (McIntosh, 1996; Phoneix, 1996; Smith and Pell, 2001; Chen, *et al.*, 2007). Also because it is related to issues such as marginalisation, poverty, the social expectations of young people, and the provision of social care, it is also a matter of social care and policy (Haralambos, *et al.* 2004, p 854, 813, and 862).



Given the multifaceted nature of the subject matter it is not surprising that different researchers, though they might have studied the same phenomenon in the same group, have yet presented different outcomes. The theoretical and epistemological background of the researcher will have a considerable impact on both the questions asked and the manner of asking thus the answer it receives. Epistemology, which deals with *how we know what we know*, is an important consideration for any research project, as research is always informed by the basis of knowledge in the mind of the researcher. This knowledge defines the angle from which the researcher will approach and make meaning of the phenomenon under investigation (Hamlyn, 1971 p 242). In other words, ultimately it defines the research question and how it is going to be addressed (as also stated elsewhere, e.g. Johnson and Onwuegbuzie, 2004; Crotty, 1998 p8- 9). Apart from the background differences among investigators, over time outside influences can also affect research and policy directions. For example, in the 1980s the pandemic of AIDS caused a shift in research and policy studies, which suddenly started to focus primarily on those who had been identified initially as being at particular risk from infection, the so-called “risk groups”. Similar efforts were made to identify individuals who exhibited more risky behaviour than did others, and to explore aspects of their psychological attributes so that they could be targeted with appropriate interventions in order to address their apparent ‘deficits’ of knowledge. As time passed, however, and more penetrative research and analysis were developed, this early emphasis on individual ‘targeting’ was supplanted by much greater attention to other issues, such as how the life context of specific groups might affect their sexual health and interactions (please see Ingham, Aggleton, 2006. p 2-3).

Research results are often impacted by the attitude or underlying motivation for the research as well. At this stage all nations but two, the USA and Somalia, have agreed to the ‘rights based’ approach, as put forward by the UN Convention on the Rights of the Child, as the preferred underlying motive for research, policy and programme development (Aggleton, *et al.*, 2006. p 3). The ‘right based’ approach, also known as the ‘positive approach’ among some researchers (Aggleton, *et al.*, 2006, p3), encourages understanding young people and health, responding to their potential and believing that young people are the bearers of rights too.

Yet this perspective is in contrast to the dominant paradigm, which persists in seeing young people as ‘collections of difficulties and problems’ that require treatment, supervision and intervention (Aggleton, *et al.*, 2006. p3). Much of the currently produced literature still has an obvious focus on problematizing the sexual health status of young people and encouraging the “adults” to take action to change the situation. This approach to policy and programme development often draws on the available research evidence, limited though it may be (Stone, Ingham, 2006, p 194). Because the focus of that research is almost always influenced by many factors, it is rarely a truly objective view of the situation. In this way it can often be a part of the problem rather than a part of the solution.

Peterson (2002) believes that the research findings among the various groups who study the sexual health of young people can also be affected by their motives, the research settings and the source of funding. He categorizes researchers into three groups based on affiliation: academic settings, the private sector, and charitable organisations. He also highlights different sources of funding—the Government, charities, private

donors and others—and indicates that this might influence the design of the research and the interpretation of results (also in Rampton and Stauber, 2001). The intention of researchers could be a factor as well, as the research might be self-generated and/or commissioned by one or more of the sources of finance (Ingham and Mayhew, 2006, p213). The researchers themselves might carry out the research from a neutral perspective, insofar as that is possible, or they may have pre-conceived ideas of what they hope to find, particularly if they are influenced by their funding source (McKee, *et al.*, 2001, ch8; Collin, *et al.*, 2002).

Ingham and Mayhew (2006, p 213) indicate that the intended audience for the research is also an important factor. Some researchers might hope to have a direct impact on policy, while others seek academic advances and chances of promotion. The types of research could be different too. Some might be theory driven and published in peer reviewed journals, others are informed by more pragmatic motives such as need assessments, audits, operations research and so on. Any of these factors could result in different interpretations of the same situation.

As this is a PhD thesis, thus an academic work whose purpose is to expand our understanding of the situation, the topic was generated based on my interest and is informed by a theoretical framework.

### *Theories informing this research*

Based on the understanding that the subject of this research can be approached in so many different ways, it is useful to think of the underlying theories as falling into one of two categories: Explanatory Theories and Change Theories (Rimer and Glanz for

NIH/National Cancer Institute, 2005). Explanatory theories describe the reasons why a problem exists, and they guide the search for factors that might contribute to the problem and can be changed—such as lack of information, self-efficacy, social support, or resources (Rimer and Glanz, p5). Change theories, on the other hand, guide the development of health interventions. They spell out concepts that can be translated into programme messages and strategies, and offer a basis for programme evaluation to help planners to be explicit about their assumptions for why a programme will work. Although Explanatory Theories and Change Theories feed each other in the process of evaluating and planning a health strategy, originally they have different questions in mind (Rimer and Glanz, 2005). This research was informed by a variety of theoretical concepts to cover its various levels, most of which could be categorised as explanatory ones. These are discussed further below.

### **3.2.1. The problematisation of young people's sexual health**

In order to provide a good grasp of the topic under investigation it will be helpful to discuss the concepts of “sexual health” and “young people” separately first, before putting them together, as throughout history each was viewed with scepticism and some levels of negativity on its own. As Aggleton, et al (2006, p1) mentioned:

“...put together the words ‘sex ‘ and ‘young people’ and there are the makings of controversy. These plus ‘drugs’ have laid the foundation for early twenty-first century understandings of young people”. The literature presented here is from 1998 forward due to the specially heavy emphasis that the topic was given in the policy documents since that time.

### **3.3. The construction of adolescence in the literature**

The concept of adolescence as a unique life stage was first introduced in 1905 when G. Stanley Hall, one of the founders of developmental psychology, published the book *Adolescence: Its Psychology and its Relationships to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education* (Hall, 1905). Coming from positivist school of thought, Hall's overall effort was to explain the phenomenon of adolescents. He mostly discussed this stage of life as saturated with negative and problematic characteristics (Hall, 1905, p 824-836). Though an exhaustive study of the history of adolescence is beyond the scope of this thesis, it seems safe to say that the notion of adolescence as a troubled time persisted through the 1950s and much of the 1960s (e.g. Freud, 1958; Blos, 1965). This view was also present in the work of psychoanalytic writers such as Erik Erikson, who saw adolescence as a period of crisis resolving the tension between identity formation and "identity confusion" (Erikson 1968/1974).

It seems that perspectives towards the whole notion of youth and adolescence began to broaden only after the introduction of constructivist epistemology in education (see Piaget, 1960, 1962, 1975) and the development of social constructionism theory in psychology (Berger and Schutz, 1967). In their book *The Social Construction of Reality*, Berger and Schutz (1967) strongly argued that truth or meaning comes to existence in and out of our engagement with the realities of our world. Making meaning of a reality is not a discovery but a construction. This has opened the gate for criticizing positivism in its different shapes while also making room for a more subjective interpretation of the reality of one's being and experiences. In this understanding of reality it is clear that

different people might construct meanings in different ways, even in relation to the same phenomenon and in seemingly the same situation (Crotty, 1998, p, 9). Although we have come a long way since G. Stanley Hall, it often seems that the literature concerning young people remains overloaded with “adults” perspective of young people’s lives and the way it is best for them to behave.

Based on these discussions, writers such as Fairweather and Tornatzky (1977) and Offer et al. (1996) argued that the notion of a problem depends on who defines it. Their works pointed to some of the myths about adolescence that require critical scrutiny, including the notion that normal adolescent development is chaotic; they argued that for many young people it is not the case. There is increasing evidence against the idea that young people universally experience puberty as a negative event (Brooks-Gunn and Reiter, 1990).

Aligned with these views, researchers such as anthropologist Margaret Mead (1928-1961) and her followers argued that the ‘problem of adolescence’ is a cultural construction with roots in history, the economy and social arrangements that deny young people opportunities and refuse to take their perspectives and experiences seriously (also in Aggleton, *et al.*,2006). In her book *Coming of Age in Samoa*, Mead questioned the inevitability of the ‘*sturm und drang*’ normally equated with adolescence (Mead, 1971, in introduction; Hechinger and Hechinger, 1963). Mead argued that in ‘primitive’ societies like Samoa, youth and early adulthood are characterised by harmony and balance (Mead,1943, p6). It is only in other *Western* societies—such as the USA and Europe—that youth is associated with problems (Aggleton, *et al.*,2006) and the lives of young people are constructed as almost synonymous with ‘risk and risk taking’ (Mitchell, *et*

*al.*,2001). This attitude of the society towards young people could sometimes be discriminative and excluding, as the notion of young people is mixed with the notion of ‘problem’ (Aggleton, *et al.*,2006, p1-4). This will become especially relevant when one considers the social construct of concepts like “high risk” and “hard to reach” as they are applied to young people today.

Sociological researchers, who tend to look at the interpersonal and community factors that influence one’s behaviour, aim to be “. . . impartial with respect to truth and falsity, rationality and irrationality, success or failure of a single phenomenon” (Bloor, 1991, p7). From a social sciences and social policy perspective, the notion of ‘dependence’ is instrumental in understanding childhood, youth, and adulthood (Alcock *et al.*,2003; Grossberg, 1994). In this view, children are those who are totally dependent on parents (or their substitutes) for shelter and care, and adults are those who are independent and self-reliant. Young people’s existence is thereby considered to be a ‘transitional’ state between ‘dependent’ childhood and ‘independent’ adulthood (Grossberg, 1994, first published in 1986; Henderson, *et al.*,2006; Arnett, 1997; Davis, 2003; see also Jeylan, *et al.*,2002).

Given the transitional nature of young adulthood, it is understandable that feeling included in one way or another would be important to young people (Alcock *et al.*,2003). This is especially relevant in any discussion of the interpersonal and community factors that influence health behaviours. Alcock and his colleagues explain that young adulthood involves a process in which one ‘leaves’ or is excluded from certain entities while at the same time one ‘engages’ or is included in others (Alcock *et al.*,2003). For example, young people leave school and/or their parents’ homes, lose their circle of school or

university friends, and lose the financial support of their parents. At the same time they are expected to enter full-time work and develop new social networks and circles of support. With this in mind, young adulthood might be regarded as a period in which interpersonal processes and primary groups are in a state of flux, and issues of social identity and role definition move to the forefront as matters of importance. On the importance of the context and its relevance to the young person's feeling of being included, Ingham (2006, p 51) discusses that the monitoring of some apparently obvious areas for inclusion is not as simple as it may at first appear. Adults may (and often do) feel that they have created an appropriate context for young people to engage, develop and foster, but the young people might not see it the same way. Furthermore, different adults may have differing intentions—those of parents may well differ from those of teachers, religious leaders, doctors, and others. This raises questions as to the usefulness of the normal criteria of reliability and validity of these kinds of measure; if different groups assess context in different ways, whose interpretation is to be afforded priority? (See Ingham, 2006, p51).

Social researchers have had an important role in extending our level of understanding about the social construct of young people's needs and behaviours. Rather than blaming undesirable outcomes on the young people's lack of responsibility, knowledge and skills, or on the Government's lack of efficiency in tackling problems, social researchers acknowledge the role each of these might play but also encourages a multi-layered analysis rather than a problem-solution based approach.



### 3.3.1 Young people and (sexual) risk

It has been argued that because dependence is a multifaceted concept that consists of financial, decisional, emotional, accommodational and relational elements, one can become independent in certain senses while remaining dependent in others (Allen, 1975; see also Smith and Mackie, 2000, p 203-247). This creates many shades of grey as young people try to move or are pushed towards an independent state of adulthood. Each step along the way is at some level linked with the desire to become an independent adult and could involve that young person in risk (Tolman, *et al.*, 2003; Pittman, *et al.*, 2001: p12-14, 25 ). Shrier and her colleagues explain that during adolescence young people begin to explore “adult” behaviours including smoking, drinking, drug use, violence, and sexual intimacy (Shrier, *et al.*, 1997). Lyng also argues that every decision to experiment with adult behaviour could be considered as involving risk (Lyng, 1990). What’s more, because adolescence is a period in which lifelong health beliefs and behaviours are established, the risk is that much greater (Shrier, *et al.*, 1997).

Though this view of equating experiments in adult behaviour with “risk” is understandable, some have also argued that this period of risk-taking is a necessary part of adolescent growth. In his book *Understanding the Adolescent*, Orvin, a child psychiatrist, explains that adolescence is a period of trial and error in many areas of life and is a necessary phase that will help the individual to shape an understanding of what he or she ultimately wants in life. Experimenting with different jobs or relationships enables them to shape patterns of desire. (Orvin, 1995, p170). He explains that social acceptance of this transitional period makes it easier for adolescents to experiment, yet some adults might see this experimentation as too unsettling thus risky (Orvin, 1995, p170). Potential conflict arises when adults attempt to keep young people within the

limits with which they, the adults, are comfortable, yet young people want to explore opportunities based on their own individual potential. Adults might attribute their unsuccessful attempts at taming young people to the young people being irresponsible and problematic. Stone and Ingham discuss the fact that adults who are in positions of responsibility could restrict young people's access to information and services if they do not agree with (or see the need for) them, which would put young people in a vulnerable position simply by virtue of their age and lack of power (Stone and Ingham, 2006, p 192).

The notion of "risk" becomes somewhat complicated when it comes to sexual activity, as sexual initiation is a part of normal human development. Nonetheless, if adequate safety measures are not taken the risk of adverse outcomes can be substantial: being in a coerced sexual relationship could result in mental and emotional complications later on; untreated STIs such as Chlamydia can result in infertility. Sexual interactions are not only a symbolic manifestation of becoming an adult, they also signify that a young person has made a 'decision' to engage in sexual activity and has gained emotional and relational independence by developing a new relationship outside the context of the original family (Singh and Darroch 2000). It is important to point out here that sexual activity, even among young people, is not itself risky *per se*, and many young people probably engage in sexual activity that has a relatively low level of risk. Young people's sexuality involves more than negative possibilities or risks (see for example Irvine 1994; Aggleton and Campbell, 2001). Sexuality is both a source and expression of critical and potentially pleasurable and positive aspects of a young person's identity. Nonetheless, the terms 'young people' and 'sex' usually occur in relation to some kind of problem.

The notion of risk is complicated, as perceptions of risk and susceptibility vary among individuals and social groups. In most studies to date it seems that the providers (adults) and receivers (young people) of sexual health information are in agreement over the conception of risk regarding the transmission of STIs and their diverse negative health outcomes, although young people might not agree with the provider's concerns in every instance (UK Collaborative Group for HIV and STI Surveillance, 2001; Allen, *et al.*, 2007). Yet other concepts of risk seem to be more worrisome to other agents in the society than they are to young people. For example, risk might be considered in terms of the burdens imposed on health care systems, which can be significant and undesirable as the cost of treating STIs and their short- and long-term complications has been rising in the past two decades or so (Social Exclusion Unit, 1999b). It was reported that an estimate of £874 million per year is spent for this purpose (Chief Medical Officer's Expert Advisory Group, 1998). In addition, from a social care point of view the risk of social exclusion is reported to be significant for stigmatizing conditions such as HIV infection or AIDS (Hughes, *et al.*, 2000).

Teenage parenthood is one area that is not clear when it comes to assessing risk. It has been discussed as a major risk from a social care point of view (Social Exclusion Unit, 1999b; Swan, *et al.*, 2003; Wiggins, *et al.*, 2007) because it is known to have strong links to social exclusion and long-term dependence on society's resources (Social Exclusion Unit, 1999b; Bonnell, *et al.*, 2003). However young people themselves may not see it as a risk, especially when they weigh the benefits of becoming a young parent against the risks (Hoggart *et al.*, 2006; Swan, *et al.*, 2003; Jewell, *et al.*, 2000). In a multi-method evaluation which looked at the issue of teenage parenthood, social exclusion and

young parents views on this situation it was concluded that teenage pregnancy is not necessarily viewed as a negative experience by many young parents (either male or female) and the negative side, referred to as *risk* by professionals, was the manifestation of social exclusion itself and not becoming a parent per se (Wiggins *et al.*, 2007).

From this point alone one can hear the cracking noise of the breakage between the providers and young recipients. It is one thing for providers to define a phenomenon differently amongst themselves, but it is something else entirely when they try to draw policies or design interventions for people who might see the same phenomenon differently. At this point one can start to realise how the concept of “hard to reach” is about to be shaped.

### **3.3.2 Social exclusion and the construct of “hard to reach” young people**

It is discussed that entering and navigating the adult world is a complex process, and every young person faces some challenges and anxieties in the move toward independent adulthood. Though many young people make the transition from youth to adulthood successfully, some do become excluded from the society for a variety of reasons (Feinstein, 1998). If the society of adults excludes young people systematically, it becomes even harder for young people to break that barrier (Aggleton, et al, 2006). The ‘rights-based’ approach suggests that the community of adults must provide the young person with the emotional, educational, mental, financial and moral support that is needed for the growth of a human being (UN Convention on the Rights of the Children, 1989). Although almost all the world leaders have signed this agreement, implementing it on a grass root level has its challenges. The world still witnesses inequalities, the social

exclusion of certain groups of young people, and their everyday challenges to survive or better their quality of life. Although some groups might not agree with the negativity attached to some of the sexual health outcomes of young people, they all agree that the social exclusion of young people is against their basic human rights and should be addressed at the policy and community level (for example see Social Exclusion Unit, 2004, 2007; UNICEF, 2001, p25; Chalmers, *et al.*, 2001). As a matter of fact, increasingly it is argued that if social inequalities are addressed the sexual health of young people would improve (for example see Roger, *et al.*, 1997; Alan Guttmacher Institute (AGI), 2001, p6).

Based on the discussion above, the risk for becoming socially excluded is known as the underlying factor for many other risks a young person might face. Social exclusion is a multi-dimensional concept that relates to the disenfranchisement or alienation of certain groups from the mainstream society. In 2007, Birkbeck College produced a report for the Department of Education and Skills identifying several risk factors that might predispose a young person to social exclusion (Birkbeck College report for the Department of Education and Skills, 2007).

According to this report, the first major risk factor includes not being in education, employment, or training, as schools and workplaces are the major institutions in the society that can engage young people during the daytime, give them a purpose in life, and consume their time and energy. These settings also provide them with opportunities to network with people, develop relationships and socialise in general (Birkbeck College report, 2007).

The next risk factor is having a deprived background (e.g. Pantazis, *et al.*, 2006; Palmer, *et al.*, 2006). This deprivation can be low family income, poor housing, living in a deprived neighbourhood or even the ill health of one's parents (Hills and Stewart, 2005). It is stated that deprivation can aggravate the likelihood of social exclusion and can bring more social exclusion in time (Smith, *et al.*, 1997).

Discrimination, which can be linked to belonging to a minority group, is also a contributing factor (Levitas, 1998; Le Grand and Levitas, 1998). According to the revised Social Exclusion Unit report (2004) black and ethnic minorities, non-Christians, disabled young people, young people with mental problems, and gays and lesbians would have a high risk for social exclusion in comparison to white-Christian-straight-healthy young people (See also Hills, *et al.*, 2002).

Running away from home and disintegration from biological (and to some extent foster) parents is also mentioned as a risk factor (Birkbeck College report, 2007).

Finally, being under 18 years of age and thus not yet eligible to vote might exclude a young person from the political decision making processes and makes them unheard and less of a priority for politicians and Governments (Matthews, *et al.*, 1999).

Although social exclusion can be a universal phenomenon and is not bound to a certain age group, when it happens in young people the effects become much more significant (Social Exclusion Unit, 2005; Acheson, 1998). According to the Social Exclusion Unit's report (2004) and the Department for Education and Skills (2004), the cycle of social exclusion can be aggravated if the young person's lack of skills or proper education could result in future unemployment and dependence on benefits; hence social exclusion at a young age can develop more social exclusion in adulthood.

When it comes to accessing sexual health information, Stone and Ingram bring forward the concept of vulnerability as it relates to young people who are excluded from the society in one way or another (2006, p192) They argue that adults in charge might intentionally exclude young people from accessing sexual health information because they believe it will encourage them to become sexually active, although the research does not back this up (Fraklin, et al., 1997; Kirby, 1997; 2001, 2002abcd, Family Health International, 2002). This vulnerability due to intentional exclusion is especially relevant for young people who might not have access to mainstream institutions (such as schools) and therefore will not receive the standard minimum sexual health education offered to young people nationwide.

Within the larger group of young people who are on the margin of the society, certain subgroups have been identified in the social policy documents and literature. These include NEET; asylum seekers/refugee groups; black and minority ethnic groups (BME); homeless and runaway young people; and sexual minority groups. Each of these groups presents a unique set of challenges when it comes to their sexual health information needs and preferences, which will be discussed in greater detail below.

### **3.3.3. The construct of “hard to reach” young people**

Populations belonging to the subgroups of socially excluded young people are sometimes labelled as “hard to reach” in the literature that deals with the provision of sexual health information and services. Yet the construct of “hard to reach” is itself worthy of investigation, as the meaning of the term seems to have undergone a shift in the past several decades and has come to include a wide variety of people. Throughout this

research quotation marks have been used around the term “hard to reach” as it applies to young people, since the idea is itself a social construct that depends largely on point of view. Before one understands the rationale behind the use of the term, one ought not be confident in using the label.

Originally the description “hard to reach” was mainly used in relation to service delivery or communication barriers. It came to be used, for example, when discussing mentally challenged groups (e.g. David, *et al.*, 1976); sex workers (e.g. Chikwem, *et al.*, 1988); prisoners and other legally challenged individuals (e.g. Mangos, *et al.*, 1990); ethnic minorities (e.g. Donovan, *et al.*, 1991; McAvoy and Reza, 1991); alcohol and drug abusers (e.g. Kandel, 1975; Zabin, *et al.*, 1986; Johnson and Delgado, 1989); runaways (e.g. Manov and Lowther, 1984); and young people outside the school settings (e.g. Luchterhand and Weller, 1979).

Beginning in the mid to late 1990s, sexual health researchers began to borrow the term “hard to reach” for HIV positive groups, (e.g. Tenner, *et al.*, 1998; Swart-Kruger and Richter, 1997; MacKellar, *et al.*, 1996; McDonald, *et al.*, 2007); sexual minorities in the context of risky sexual behaviour (e.g. Johnston, *et al.*, 2008; Amirkhanian, *et al.*, 2005) and adolescents (e.g. Osborn, 2006; Beck, *et al.*, 2005). In all these works a prominent link has been made between the use of the term “hard to reach” and the concept of vulnerability and risk attached to the target group.

Primary Care Trust publications, policy documents and Governmental reports also use this term in the context of offering solutions and making it possible for particular groups to access information and services (e.g. Department of Health in The national strategy for sexual health and HIV, 2001). However, the term “socially excluded” is



preferred when discussing social equity and human rights, as it takes the burden off the target groups and instead puts the responsibility for exclusion on different factors (including environmental and political).

Generally speaking, the term “hard to reach” is used today to describe those individuals who experience a lack of access to available information and services for a variety of reasons including having difficulty in communication. However a general review of the literature reveals that wherever there is a discussion of an unmet expectation the possibility for using this label arises. In other words, whenever health services and/or information fail to achieve the desired outcome there is a great temptation to label the intended audience as “hard to reach”. When it comes to the provision of sexual health information this is especially problematic, as the label “hard to reach” takes the focus off the potential shortcomings of the information provided and prevents a further line of questioning regarding the appropriateness or usefulness of the materials and the efficacy of the method of delivery. Though it may be subtle, there is nonetheless a difference between the statements “we failed to reach them” and “they are hard-to-reach”.

In many ways the construct of “hard to reach” also has to do with what is and is not considered normative within the society generally. It is expected in most Western societies that a young unmarried person is either studying, being trained for a profession, or otherwise employed. Most societies likewise expect that that a young person does not become a parent before he or she gets married or becomes financially secure (Campion, 1995). And though single parenthood is more acceptable than ever, the stigma attached to being unmarried, young and pregnant still exists as a global phenomenon (May, 2003;

Roxberg, 2007; Kiernan, 2004). Society also ‘expects’ that a young person behave responsibly when it comes to sexual behaviour, and most people would agree that safer sex practices are a good idea (Brewster *et al.*, 1993). These social expectations or norms dictate what is and is not expected and acceptable to the majority of participants in a given society (Allen and Bragg, 1965; Allen, 1975).

At the same time, all these ‘expectations’ and exclusions also reflect how society constructs an outsider or an excluded group, as anyone who does not conform to these expectations may be seen as different, thus deserving of a defining label such as an ‘outsider’ or ‘deviant’ (Becker, 1997, p 8-9). Deviance is a term used by social researchers to describe a person or group who do not conform to the social norms of the majority (Akers, 1968).

There is an implied sense of belonging for the ‘insiders’ of any group, and when people feel they belong to a group the likelihood of social conformity and complying with norms and expectations increases (Dunne, 1999; Allen, 1965). The opposite applies as well: a socially excluded young person who is marginalised and isolated does not feel like part of the bigger society and so might not feel obliged to conform to its norms and expectations. What’s more, research indicates that when a person or group is given a label, and they are aware of it, they tend to start behaving in a way that conforms with the label. This acting out is based on their own perceptions of the characteristics belonging to a person so labelled (Lauchlan *et al.*, 2007; Rathbone, 2008).

I was not able to find any research (at least in English) which discusses labelling in the context of “hard to reach” young people, but it seems logical to question whether or not the label itself pushes them in a certain direction, as has been discussed in relation

to the use of other labels for groups of young people such as ‘gang members’, ‘youth offenders’ or ‘those in need of special education’ and so on (e.g. Dempsey, *et al.*, 2001; Lauchlan *et al.*, 2007; Rathbone, 2008).

Even in today’s multicultural Britain, the mainstream, acceptable socio-cultural class seems to be the “white” middle-class and its culture. This notion was discussed in the context of educational achievements by Gillborn and Youdell (2000) and was referred to as *racialised expectations*. In other words, while some rules and expectations might seem natural and normal for a young person from a white middle-class background, they will not necessarily apply to young people from different ethnic, racial, or socioeconomic backgrounds. For instance being a teenage mother might be frowned upon in a specific community or within a particular social class while it might be increasingly acceptable for other communities or social classes (Arai, 2007). It is conceivable that the young mother who lives within a community in which teenage parenthood is acceptable might not see herself as suffering from social exclusion. Not everyone longs to belong to the mainstream society or live according to its norms and dictates.

Interestingly, it seems that in many cases young people are unaware of the labels that are used by policy makers and researchers to describe certain groups among them. A relatively recent review by the Policy Watch (Nov, 2008) looked at the meaning of NEET for young people who are categorised in this group in the social policy documents. They reported that none of these young people had even heard about the term and did not know what it meant. In light of this, one of the aims of this research is to explore the construct of “hard to reach” as it is viewed by the young people to whom it applies.

### **3.4. Sexual Health Needs of Socially Excluded Young People**

In 2008, it was estimated that 78,000 young people aged 16-17 and 466,000 young people aged 18-24 were not in full-time education and were unemployed (Office of National Statistics, Nov 2008). However, formal reports indicate that an estimated number of NEET cannot be derived from current statistics.

As might be expected, socially excluded young people are not a homogeneous group, and their sexual health information needs will vary according to their circumstances. The list that follows identifies the subgroups of socially excluded young people that have been introduced in the social policy documents and literature. This group of young people includes a variety of individuals with different and sometimes complex support needs. It is suggested that sexual health information provision should be tailored to their individual needs and should allow participants to take ownership of the activities in which they engage (Golden, et al. 2004).

There is an overall dearth of knowledge about the sexual health status of this group of young people and their needs and preferences regarding sexual health information, and one of the aims of this research is to increase our understanding in this area.

#### **3.4.1. Asylum seekers and refugee groups**

In an innovative guideline published by the Teenage Pregnancy Unit in 2006, young immigrants and refugees who are new in the destination country were identified as an important group on the verge of social exclusion. When they enter their new homes they are confronted with a myriad of factors that exclude them from the rest of the society:

language barriers, culture shock, unemployment and losing networks of support (also supported by Young, 2006 and Burnett, 2001; Allan and Clarke, 2005).

As a part of Young's guideline (2006), professionals flagged isolation as one of the main factors preventing this group from gaining knowledge and accessing the services they need. Further, they linked social isolation to emotional vulnerability, sexual exploitation and having limited opportunities to form friendships and also to have healthy sex lives. Unaccompanied Asylum Seeking Minors themselves described isolation and mixed experiences of forming friendships as the main reasons for their marginalisation and inability to achieve better health outcomes (also see Bradford, *et al.*, 2007).

Data from the Office for National Statistics has shown that a significant number of Unaccompanied Asylum Seeking Minors will arrive in the UK already infected with HIV, whether this has been diagnosed or not (O'Sullivan, *et al.* for ONS, 2005).

It has been shown that unaccompanied asylum-seeking children and young people have complex health and social care needs and sexual health is among them (Thomas *et al.*, 2004). The fact is that many of these young people did not receive sex education at school in their home countries; they left their countries usually in crisis situations; they often have traumatic backgrounds (including sexual violence or rape); they do not know the language and they live in isolation without their parents. Taken together, these factors make them one of the most at risk groups for social exclusion (Thomas, *et al.*, 2004; Bradford, 2007). Providing for their sexual health information needs would seem to require an understanding of their complex situations and the use of methods that have been proved to be successful in identifying the needs of marginalised and socially excluded young people.

### **3.4.2. Black and Minority Ethnic (BME) groups**

Another criterion for being prone to social exclusion is to belong to black and minority ethnic groups (e.g. McGarrigle, *et al.*, 2002). This subject has been studied through many different lenses. One cross sectional survey studying the sexual behaviour of 15-18 year old students belonging to different ethnicities found that behaviour is not consistent from one ethnicity to another (Coleman and Testa, 2006; see also Fletcher, 2003, Hughes, *et al.*, 2000; Monteiro, *et al.*, 2005; Mirza, 1992). Adam and colleagues (2000) also discuss in depth how the perception of risk differs among cultures, and suggest that different ethnic groups might have different needs to ensure their better health outcomes (Adam, *et al.*, 2000; see also Ghuman, 2003).

In the UK, most research on immigrant groups has been focused on asylum seekers and refugees who might have specific needs due to their socio-economic or political backgrounds. Research conducted in Canada, with general population of immigrants has indicated that language, culture and religion each have a role in the social exclusion of young immigrants, therefore their healthcare needs have to be met considering these factors (Zanchetta and Poureslami, 2006; see also Maticka-Tyndale *et al.*, 2007). Many immigrants come from countries where sexual health education is not part of their school curricula and for a variety of reasons they might not want or be able to access the information they need, which can contribute to their unwanted health outcomes (Singh, *et al.*, 2001). New immigrants also tend to be unfamiliar with the healthcare systems of their destination countries; they do not know how the system works, what their entitlements are and where they can access services (Zanchetta and

Poureslami, 2006), all of which can contribute to a higher risk of social exclusion (Young, 2006; Social Exclusion Unit, 2004) and poor health outcomes. This would also apply to irregular immigrants (e.g. students) and those who lack a secure immigration status in the destination country (Simich *et al.*, 2007).

### **3.4.3. Homeless and runaway young people**

Homeless and runaway young people are also counted among socially excluded youth, and they are at greater risk of unprotected sex, needle sharing and sex work—also called ‘survival sex’ (Social Exclusion Unit, 2004; Department of Education and Skill, 2004). Some of these young people are also more likely to be victims of sexual violence or abuse before running away from their homes (Christensen *et al.*, 2005).

Unprotected sex among homeless and runaway young people is not an uncommon practice (Haley *et al.*, 2004), though the reasons have less to do with knowledge deficit than with the nature of those sexual contacts, which are mainly for receiving favours, shelter or money that can help them survive in that situation (Bonell, *et al.*, 2003; Wojcicki and Malala, 2001). Once the practice of unsafe sex becomes common, they also tend to take higher risks and not use condoms for their non-commercial partners (Haley *et al.*, 2004; Smith and Rosenthal, 1995).

Providing for the needs of this group of young people is very challenging as sexual behaviour and risk taking in these circumstances are not necessarily determined by lack of knowledge, but become a result of external forces and later on established habits and general attitude of not caring (Lyng, 1990; Cooper, *et al.*, 2001). The information they need might range from basic sexual health-related information to more complex

information and counselling to help them analyse their situation better and be able to recover from any trauma they might have experienced in the past (Turning Point/IPPR, 2004).

A comparison study in the USA (Ensign and Santelli, 1997) showed that there are significant differences between street youth (homeless young people who live on streets or double up with friends or lovers) and system youth (young people involved in foster care). The former group had considerably higher-risk sexual behaviour and the incidence of forced sex was much higher in them. The study also found that the knowledge of parents and causes of homelessness provide important contextual information about their risk profiles and information needs. System youth are at risk for other reasons. First, they can go in and out of care very easily and the network of support does not extend automatically, which means they lose their supports when going out of care. Second, foster care is not the same as being in a loving and supportive family; while education and information might be provided, without the proper context the effect can be lower. Third, when someone is in care, the concept of risk and priorities are different. The needs are different as well (Ensign and Santelli, 1997).

#### **3.4.4. Sexual minority groups**

There are very few studies looking at gay, lesbian and trans-sexual young people and their sexual health information needs. In studies with gay populations over the years, Bakker and Cavender (2003) have highlighted how marginalised, stigmatised and invisible gay young people might be, and how their ignored and unaddressed needs could place them at higher risk. Bakker and Cavender (2003) emphasise that a non-biased



workforce is necessary to identify and address the needs of gay men, lesbians, and transsexual young people. Evidence shows that counselling and advice services for homosexual young people in particular are scarce and inaccessible, and it has been suggested that this can cause young people to delay “coming out” as openly gay, which puts them at greater risk and with significant unmet needs (Fontaine and Hammond, 1996). When they cannot express their sexual orientations openly, and the educators are not trained to explore this issue delicately, the chances are that homosexual young people will be left unsupported and without sufficient information to protect themselves mentally and physically (Bakker and Cavender, 2003). Regretfully, it seems that most literature on gay and lesbian young people was published in late 1980s and early 1990s; their needs and issues seem to be a forgotten matter in the 21<sup>st</sup> century.

In this research, I have focused on young people who met at least one of the main risk factors of social exclusion mentioned in the reports of the Social Exclusion Unit (1999b, 2004): those who are not in education, employment, or training (NEET). As has been mentioned, this is not a homogeneous group and can include individuals who also fall into one of the subgroups listed above.

### ***3.5. The role of perception in influencing sexual health information needs***

An individual’s ability to access sexual health information and services is certainly affected by the availability of those resources. However, it has also been proposed that in order for individuals to seek out and benefit from sexual health information and services successfully they must first perceive themselves as being *susceptible to risk*, which

means that they have to see that they are not invincible when it comes to getting pregnant or contracting an STI. They must be convinced of the *severity of the condition*, see the *perceived benefit*, and weigh the action against any *perceived barriers*. In this stage they will evaluate the potential gains and losses to determine whether or not the new behaviour is worth the trouble, so to speak. The final step is a reminder from an external trigger, such as an advertising campaign, which acts as the *cue to action* (Becker, 1974; Hochbaum, 1958; Rosenstock, 1966; Rosenstock, *et al.*, 1974, p 150; also see Rosenstock, *et al.*, 1988). Apart from the *cue to action*, the individual is seen as the responsible agent in initiating health-related behaviour; in other words, the individual is the social agent who makes sense of the reality of his/her own world.

Another consideration is how the individual's cognition is shaped to evaluate the data he/she receives, to resolve conflicting attitudinal and belief factors, and finally to adopt the desired behaviour (please see concept of self-efficacy in Rotter 1954 and Bandura, 1977, p 79). Finally, many researchers include the *attitude* of the person (Ajzen, and Maden, 1986 ; Ajzen, 1992) as the most important link between knowledge and behaviour. A young person might know how to use a condom, and know that it is the right thing to do, but if she has the attitude that it is not "cool" to use condoms she is not likely to use one regardless of the perceived risk. The negative values that are attached to a behaviour have an effect on the individual's attitude towards that specific behaviour (Crepaz and Marks, 2002; Schaalma, *et al.* 1993).

Based on the concept as discussed so far, one can see how socially excluded young people might fall out of the scene as their life circumstances and social context might not put them in a position to make a risk/benefit assessment of any given action.

Many “hard to reach” young people might have competing priorities which do not include the acquisition of sexual health information to protect themselves (Social Exclusion Unit, 2005). For a homeless or runaway young person, the *perceived risk* of dying of cold or hunger will be a higher priority than the *perceived risk* of not having sufficient sexual health information to prevent infection with an STI. For those who sell sex for money, favour, shelter or affection, again the role of knowledge is minimal in the whole context of their lives (Melrose and Barrett, 2004; Cooper, *et al.*, 2001). In the context of sexual health information provision for “hard to reach” young people, some researchers argue that there are many different factors involved in the process of decision making and sometimes a decision is not even considered (Commission for Social Care Inspection, 2007). Furthermore, having information about an action does not necessarily generate it (Akerlund and Cheung 2005; Ward 1999; Moore and Charvat, 2007).

Throughout the decision-making process other factors might come into play that could influence the individual’s perception of need for services or information, his or her ability to act on this perception, and the way he or she will go about it. Among these factors, the role of gender is the one most highlighted by researchers (Melendez and Tolman, 2006, p 32-33). In the context of global literature it is documented that most cultures perceive women as passive sexual beings who are not supposed to be sexually active; young men, in contrast, are often under pressure both to be sexual and to “know it all” (Dowsett *et al.*, 1998) The extremity of these positions will vary in different cultural settings, and the current trend is changing quickly, yet this remains the prevalent view. These contextual influences can affect sexual health information seeking behaviour, though they do not always. The sexual behaviour pattern of the two genders might not be

the same either. Although in some countries such as the United States and United Kingdom the onset of sexual activity is reportedly the same for males and females, in many other countries men tend to report earlier sexual initiation than women (Population Information Program 2001; Singh, *et al.*, 2000, Youn 2001). Another gender related difference is the link, for females, between being a good girl and not having/wanting sex; there is no similar edict for males (Rosenthal and Smith, 1997).

West and Zimmermman (1987) explain that cultural structure can influence the individual's perception of the set of criteria a particular gender should own. They introduce the concept of 'doing gender', and refer to the role of social and cultural expectation in shaping the individuals' perception of the attitudes and actions that are expected from them (West and Zimmermman, 1987). This could inevitably affect the information seeking behaviour of young people, as well as the gender-specific needs they might develop (Griffiths, *et al.*, 2008).

All the theoretical concepts discussed above are relevant and could be used to describe any groups' issue of health behaviour or information acquisition. The part that needs further investigation seems to be the specific areas in these models that could be different for "hard to reach" or socially excluded young people than their peers. For example the parts that shape their perception of themselves (as individuals and as parts of a specific group in the society), their perception of need to access certain type of information, their social capital (i.e. their environment, who surrounds them and who might influence the acquisition and evaluation of the information they receive), and the potential internal and external barriers they perceive as preventing them from accessing the information.

### **3.6. Sexual health information provision initiatives for young people outside schools**

If one accepts that formal sources of sexual health information are less influential than educators had hoped, it follows that there must be other sources of knowledge and information that do exert influence on the sexual relationship decisions of young people (Mason, 2005; Philo, 1990). These alternative sources of information can be in different formats and can originate from a variety of sources, and one of the objectives of this research is to identify them and explore their importance. However, this research does not intend to prescribe any particular course of action, or to give a layout of best practices for more effective action in the future. Rather it has been designed to analyse these sources of information with respect to their role as influencing factors that shape the knowledge and perceptions of young people in regards to sexual health information.

#### **3.6.1. Media**

Young people use media quite extensively, and much of what they watch, read, and listen to is geared specifically toward them. It has been suggested that media is one of the main sources of information for young people (Macdowal, *et al.*, 2006).

According to the findings of previous research, media messages are influential in two different ways: content and representativeness (Kitzinger, 1999; Brown, *et al.*, 2001; Croteau and Hoynes, 2000; Colle, 1973; Ross, 2000). Kitzinger explains that content here refers to the accuracy, quantity and type of message provided (Kitzinger 1999).

Representativeness, on the other hand, refers to messages being pertinent and applicable

to the diverse groups who view the programmes (Colle, 1973; Croteau as discussed by Croteau and Hoynes, 2000).

If we look at the portrayal of sex in all these media we rarely see mention of sexual health information. A content analysis of some major teen soap operas and popular magazines targeting teenagers in the UK revealed that contraception or protection against STIs were never mentioned in any of the teen dramas that were analysed (Batchelor *et al.*, 2004). Unlike the TV sample, sexual health issues did feature in the magazines, several of which included information about contraception, however there was no discussion of how to negotiate the use of any contraceptive device or implement safer sexual practices. There was also no mention of contraceptive or safe sexual practices in any of the fictional love/sex stories published within their magazine sample. These findings are quite important and highlight the gap in collective knowledge about sexual health as represented in mass media and press that targets young people.

One of the interesting findings of Batchelor and his colleagues was that most of the teenagers represented throughout their sample were white, thin, conventionally attractive and had no evident disability (Batchelor, *et al.*, 2004). There were also no examples in passing of positive portrayals of openly gay men or women. Badawi and Colle have each argued that if minorities are not included in stories or visualised in messages, or if they can not identify with the image which represents their community, one cannot expect to have an impact on these populations (Badawi, 1994; Colle, 1973). Magazines, the Internet and radio programmes have a similar situation and the argument put forward for TV content applies to all other types of media (Brown, *et al.* 1993; also see Strasburger, 1995). If socially excluded young people are under-represented in media

and magazines, if their issues and needs are considerably ignored, then it becomes harder for them to find a positive and representative role model to look up to and learn from. Yet, if this point is taken into consideration, young people from ethnic minorities can be influenced positively by programmes delivered to them via mass media (Delamater, *et al.*, 2000; Kalchman, *et al.*, 1999; Gruber and Gruber, 2000; Solomon and DeJong, 1988; Gilmore, *et al.*, 1997).

Despite these shortcomings in the mainstream media, an argument has been made that media in general, and new media forms in particular (such as text messaging and the Internet) do have tremendous potential for reaching young people, including those who are considered “hard to reach”. A study in Australia (Wilkins and Mak, 2007) evaluated the effectiveness of text messaging as a form of sexual health education. The results showed that Chlamydia testing increased significantly during the campaign period and partner notification improved, particularly in females. Participants of the study predominantly nominated television, radio, posters and magazines as preferred media for receiving sexual health messages. They also preferred to obtain sexual health information through the Internet or a health professional.

These findings reinforce the argument that although the information provided by school, parents, or in healthcare settings might be necessary (Swanne, *et al.*, 2003; Chambers, *et al.*, 2002), there are also many other potential resources that might help to create a basis of knowledge around sexual health. These resources become particularly important for socially excluded young people who do not live with parents for different reasons (Kiernan, *et al.*, 1997; Aggleton and Campbell, 2000), have high truancy rates, or

do not access health services unless they have to (e.g. Edgecombe and O'Rourke, 2002; Hayter, 2005; Hosie, *et al.*, 2005; Aggleton and Campbell, 2000).

### **3.6.2. Outreach work**

The concept of outreach work was developed in response to criticisms of policies and strategies in place. It was a result of the shift from blaming young people to taking responsibility for the fact that the resources were not designed to be appealing or relevant to certain groups (Aggleton, *et al.*, 2006, p 4).

Outreach work is meant to be a proactive approach that aims to reach out to young people, identify their needs and support them with information and services. Usually it involves a nurse, social worker or youth worker who goes into the community and tries to find “hard-to-reach” young people where they live. Some outreach services use peer educators as their frontline workers. According to the National Development Project Steering Group of the National Youth Work Agency for Scotland (<http://www.youthlink.co.uk>):

*“Outreach work is normally related to services which are available elsewhere [rather than in the schools] and is generally aimed at feeding young people in to those services. Whilst it can and does take place on young people's own territory, it can also include work in existing young facilities, educational institutions and commercial settings. It is characterised by purposeful interaction between youth workers and young people and involves contact information giving, and the invitation to join existing or proposed youth programmes and other services designed with them in mind”.*

There is some evidence supporting the effectiveness of nursing outreach clinics for marginalised youth (Hayter, 2005). One seeming advantage of the use of outreach clinics is that any opportunity to socialise with peers is very appealing to socially



excluded young people (Hayter, 2005). When they gather in these settings and find them to be non-judgemental and trustworthy, they tend to open up, ask questions and seek advice and support. This finding was corroborated in another evaluation conducted on the Health Bus concept that was implemented in two inner London boroughs since 1996 (Edgecombe and O'Rourke, 2002). Though the Health Bus was a slightly different programme in that it consisted of a mobile unit that actually went to places that socially excluded people gathered and proactively targeted them, the take up by marginalised young people was generally high. It was also successful in attracting young men, who are traditionally known to be harder to include when it comes to sexual health services (Edgecombe and O'Rourke, 2002; Aggleton and Campbell, 2000). The educational impact of this service persisted over time, however the evaluation did not include the long-term effects of advice given. This is a gap which few studies on socially excluded young people have been able to address.

### **3.6.3. Peer Educators (PE)**

Peer-led education was initially piloted and implemented in mainstream sex education at schools. The concept of PE was shaped after studies showed that young people tend to trust their peers more than adults and will sometimes draw on them for education and support (Parkin and McKeganey, 2000; Ziersch *et al.*, 2000; Backett-Milburn and Wilson, 2000).

Though peer-educators can perform both inside and outside schools, this research focuses only on those who work as outreach workers with socially excluded young people outside the school setting, as the setting itself, their backgrounds and their target

population are vastly different than those who work within schools (see also Baraitser, *et al.*,2002). With this in mind, the Family Planning Association (FPA), working with the National Youth Agency, has developed a set of core competencies which cover all the essential skills, information and values youth workers (and all people who work with young people including PEs) need in order to run safe, informed, and practical sex and relationships work sessions with young people (FPA website, Available from: <http://www.fpa.org.uk/>. Accessed 25 Nov 2008). This competency list was prepared in consideration of the fact that in a real-life setting, young people might come from a variety of different backgrounds, knowledge bases and age groups. Therefore workers need to be able to work comfortably with diverse needs and demands. This can sometimes be a challenge for youth workers, though it can also help to develop their assertiveness and communication skills and help them learn more about services available for different people in healthcare settings (Stephenson, *et al.*,2004; Forest, *et al.*,2002).

In one project it was established that peer education is particularly useful for socially excluded young people (Parkin and McKeganey, 2000) and several young organisations such as Brook's and Barnardo's utilise them. They are also relatively cheap resource to recruit and use in outreach services. However by and large the study of the effectiveness of peer-educators for socially excluded young people from an outcomes-oriented perspective has not been attempted. This is likely due to the fact that socially excluded young people are not easily accessible for follow-up.

Instead the research seems to have focused on the impact of training for the peer educators themselves. One of the studies that looked at the role of peer educators was an

outcome and process evaluation of a pilot programme for male sex workers in London (Ziersch *et al.*, 2000). They trained male sex workers and asked them to provide peer education to other young people who worked for three agencies. The feedback from participants demonstrated how challenging the role of peer educators was and how difficult it was to get people to confide in them. There were some upsides, such as being more available as a source of information and being able to communicate with the target group in the same language, but young people expressed that they preferred to speak to a 'professional' who was more knowledgeable and trustworthy from the confidentiality point of view. The peer educators also had difficulty in securing management support in their work, and because they were socially excluded themselves, they had to deal with other problems (such as their own poverty), which made them less accountable for the role that was delegated to them.

A qualitative study in Scotland found that working as a peer educator can contribute to the personal development of the educator himself (Backett-Milburn and Wilson, 2000), therefore the authors argued that peer education at least has very strong benefits for the socially excluded young people who volunteer to become peer educators (see also Stephenson, *et al.*, 2004; Baraitser *et al.*, 2002). It seems significant, however, that this finding actually could put the whole notion of peer educator programmes under question, as young people who are given the opportunity to participate in institutionalised educational programmes in essence no longer belong to the socially excluded group from which they were recruited. This could potentially lessen the efficacy of the services they provide by lowering their contacts with their former peers and also by causing them not to see themselves as belonging to that group any longer (Collumbien, *et al.*, 2006, p 167).

There is some research demonstrating that peer educators continue to have the potential to be seen as a trusted resource for socially excluded young people (Sharp, 2001; Shineer, 1999). However, this research is drawn from an internationally accumulated literature thus its applicability to different groups of young people in different cultural settings could be questioned. One of the reasons peer educators are included in this research is that they are likely to have seen both sides of the story, from the user point (a socially-excluded young person) as well as from the provider point (peer educator).

Another interesting finding of Becket's evaluation was that not only do the peer educators have a short-term view about their careers (as it is probably not a viable investment for them), but also the management of these programmes (in particular those working at a community setting) changed quite frequently and this significantly affected the continuity of the service. Therefore, although peer education has been viewed as an interesting policy, there are still significant organisational and human resources challenges to make it a mainstream service.

#### **3.6.4. One-Stop Shops**

According to the One-Stop Shop Evaluation Team, the overall philosophy is to provide a variety of services in one setting. Because young people use services very sporadically, once they enter a point-of-service it is useful to have everything available so that all the services can be provided in that one visit (French, *et al.*, 2006). Another advantage has been the de-stigmatisation of using sexual health services in general. Young people usually feel uncomfortable using sexual health clinics or family planning services, as they fear that people might recognise and judge them. However if they are going to a youth

centre or a clinic with many services on offering, nobody can tell why they attended that centre. Thus it can potentially increase the chance of a young person seeking out services and information (also supported by Viner and Barker, 2005).

### **3.6.5. Taking every opportunity to teach young people about sexual health**

Finally, the fourth method that is recommended is to use every contact with a young person as an opportunity to answer questions and provide sexual health information (Rogstad, *et al.*, 2002). For example, if a young person attends a clinic or service to obtain condoms or seek treatment for an STI, the service should be prepared to use that opportunity for education, information provision, answering questions and giving advice (Mitchell, *et al.*, 2002; Esu-Williams *et al.*, 2004; Awasthi, *et al.*, 2000, Hughes, *et al.*, 2000). In the *Standards for comprehensive sexual health services for young people under 25 years* (Rogstad, *et al.*, 2002) it is emphasised that all staff should be trained in this opportunistic type of education so that they might give the young person a chance to ask his or her questions in a confidential and trusted environment (also in, Sex Education Forum, 1999).

### **3.7. Concluding remarks**

It has been already established that lack of knowledge plays a direct role in the risky behaviour of at least some socially excluded young people. However, there is a rich body of literature supporting the idea that knowledge is not enough (e.g. French, 2002). In other words, the problem seemed to be less about a lack of available information and more about the way information is presented and whether or not it is personalised. These

findings have been supported by other studies and documents (Aggleton and Campbell, 2000; Power, *et al.*, 1999; Roger, *et al.*, 1997).

Furthermore, other research have indicated that young people have very different perceptions and beliefs about family planning resources and this directly impacted their health seeking behaviours (Harden and Ogden, 1999; see also Counterpoint, 2001). The authors suggested that embracing rather than challenging this variability could promote contraception use in young people. In other words, information about contraception services can be designed to be in line, rather than in conflict, with young people's existing concerns and beliefs (Barna, *et al.*, 2002). This seems to be quite an important observation as it highlights the significance of personalisation of sexual health information, so that the types of information and courses of action are most suited to the young person's individual needs and relevant to his or her context of life. (Aggleton and Campbell, 2000).

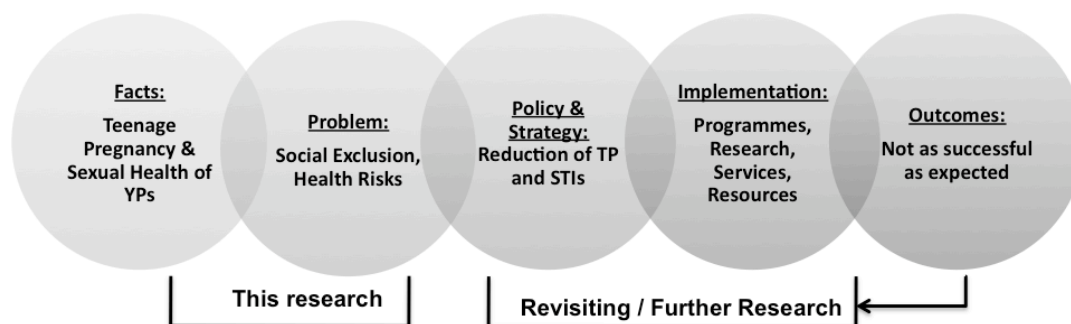
Thus far what has been well-researched about the needs and preferences of socially excluded young people is that their lines of reasoning and risk perception are fundamentally different from those who are less deprived (Counterpoint, 2001; Smith and Rosenthal, 1995; Social Exclusion Unit, 2004; Adler, 1997). They do not attend schools as regularly as others; therefore, they might miss PHSE and SRE sessions (Social Exclusion Unit, 2004). Instead there are different sources of information, formal and informal in nature, which influence and shape their knowledge about sexual health (Marson and King, 2006; Abraham, *et al.*, 1991; Brown et al 2001). Although use of mass media could potentially be helpful with these young people, they are less likely to respond to media campaigns (Agha, 2003; Villani, 2001). Therefore, campaigns such as

‘RU thinking’ and ‘Want Respect? Use a Condom’ are basically designed for and targeted to a general population of young people, not the socially excluded ones in particular. They are harder to reach and services designed for young people might not be accessible, suitable, or sensitive enough for them (Hoggart, *et al.*, 2006; Acheson, 1998; Counterpoint, 2001).

In this chapter, informing theories and models for this research and the relevant literature were discussed. The literature was presented from the main disciplines that have studied sexual health, adolescents/young people and their needs for sexual health information. The intersection between theories that informed them was also discussed. Several gaps were identified. First, there seems to be a lack of understanding regarding young people’s perception of their need to seek sexual health information. Second, there is little known about the influencing factors that shape this perception. Third, there is an overall lack of representation of the group of young people who are referred to as “hard to reach” in the literature.

### **3. 8. *Implications of Literature review for this research and the data collection***

This research aims to better understand the sexual health information needs and preferences of young people labelled as “hard to reach.” As has been discussed, most discourses to this point have been firmly rooted in the practical implications of this topic and have focused on sexual health strategies and outcomes, as illustrated in the diagram below.



From left to right the diagram lays out how the policy context was shaped by an interpretation of the available evidence regarding the sexual health status of young people in Britain. These interpretations led to the formation of a problem; policies and strategies were designed to tackle this problem; they were implemented; and the outcomes were assessed and discovered to be less successful than expected. In subsequent years, action research, policy analysis, outcome evaluation and surveys were conducted to evaluate programmes, services and policies in order to discover how the policies and strategies could be more successfully implemented to achieve the desired outcomes. The main body of the literature around the sexual health of young people was influenced by these perspectives.

This research, in contrast, offers a broader analysis by looking at the issue of sexual health provision for those considered ‘hard to reach’ from the perspective of social constructionism—the idea that reality is socially constructed and, following a sociology of knowledge approach, the research must aim to analyse the context in which sexual health provision is offered and accessed. It agrees with the argument of Berger and Luckmann that studying knowledge without analysing the context in which that knowledge is meaningful seems pointless (Berger and Luckmann’s, 1967, p19). It was designed to go back in this sequence and focus on increasing our understanding of the



situation rather than improving the outcomes. It does so by approaching the question from multiple angles: professionals who deal with this population, peer educators, and the young people themselves. The research is grounded in the effort to understand how much need the target population feels to seek out sexual health information and whether they believe their actions to seek information can reduce a potential health threat at an acceptable cost (Rosenstock, 1974, p10).

Putting everything into this context will shed some light on how the need for sexual health information might be shaped among groups of “hard to reach” young people. In the chapter that follows I will discuss the theoretical underpinnings upon which this research is built, including the social construction of the label formation of the “hard to reach” as applied to this group of young people

## **Chapter 4: Methodology and Method**

This chapter will provide a detailed account of the theoretical underpinnings and practical methods used in this research. It will begin with an explanation of the choice of method for data collection and analysis and will go on to cover the interview process, the development of the interview guide, the recruitment process, ethical considerations, and the method of data analysis. Finally, at the end of this chapter I discuss validity and reliability of the findings within a framework suitable for qualitative research.

### ***4.1. The choice of qualitative research method and theoretical underpinnings for this research***

Because this research sets out to explore the variety of ways in which the social context of a young person's life may influence his or her perception of need regarding sexual health, it seemed most appropriately suited to a qualitative research methodology.

Generally speaking, qualitative research attempts to understand how social context influences a given phenomenon. It is grounded in the Interpretive Tradition, which takes the position that any study of human behaviour must consider the social context that shapes such behaviour (Bryman, 2004, p13, 540). Based on this view, the most pertinent questions are not about the 'reality' of the world, but about the individual's interpretations of it. In this study, the main avenues to be explored were: who is seen as a "hard to reach" young person when it comes to delivering sexual health information; who defines this group as such; do the "hard to reach" young people themselves identify with this categorisation; and, consequently, does this have any effect on their understanding of their needs for sexual health information? The methodological approach for this research is the interpretive tradition using the principles of phenomenology to understand human

experience. However, the method for data collection and analysis was adapted from Interpretive Phenomenological Analysis (Smith and Eathough (2007).

Soriano emphasises the importance of a qualitative approach “. . . when the researcher or practitioner does not know much about the needs and preferences of the target population” (Soriano, 1995, p50). Thus a qualitative approach enabled me to emphasise the individual while at the same time giving me the opportunity to see him/her in his/her social context. This is something that does not usually happen in survey-based work - which could have been an alternative approach for the present study (Soriano, 1995; Hesse-Biber and Leavy, 2004).

Although I explain the themes that emerged in the context of individuals’ lives and the wider social context, the main intention was to provide a better understanding of these issues and to shed light on existing patterns rather than to develop a theoretical explanation. Creswell states:

“.... The researcher collects open-ended data with the primary intent of developing themes from the data....” (Creswell, 2003; p18).

Later in this chapter I will discuss how I made use of open-ended questions and in the following chapter the themes that emerged will be introduced in some depth.

A qualitative approach is also highly valuable in research where the aim is to compare different point of views on the same subject (Maxwell, 1996). This study involved participants from three different groups; professionals (educators), peer educators and “hard to reach” young people; with the aim of comparing the views of

these three groups to gain some understanding of the context for providing or receiving sexual health information with “hard to reach” young people.

#### ***4.2. Data collection/management and analysis***

Reviewing the literature one finds that the use of qualitative techniques, especially interviewing (in-depth and semi-structured) are seen as increasingly important in studies where participants are treated as individuals, rather than as parts of a defined category, and their individual take of the situation is considered important (Bryman, 2004, p.13). This was particularly useful when interviewing a group of young people who were labelled “hard to reach”. However the heterogeneity of this group was itself to be taken into account as there was complexity regarding the variety of social backgrounds of the participants. Using a single label to address them by no means indicates that all of these young people came from the same background or had the same life experiences. Thus their individual perceptions of themselves, their needs for information, and their behaviour preferences were idiosyncratic and had to be considered throughout the research process.

I set out to preserve individuality for the participants by letting them have their say based on their own experiences – and as they were shaped by their social backgrounds. However, I also tried to make sense of these young peoples’ experiences as a group as well. For this I used the computer assisted text analysis software WordStat 5.1 ([www.provalisresearch.com](http://www.provalisresearch.com)). This software is designed as a more advanced version of Nu\*Dist and NViVo which are more commonly used among qualitative researchers working with large text data sets. It has the capacity for integrated text mining analysis

and visualisation tools (clustering, multidimensional scaling, heatmaps, correspondence analysis) and is able to create a hierarchical categorisation of dictionary or taxonomy supporting words, word patterns, phrases and proximity rules.

#### **4.3. Data Saturation**

At the time of the interviews, there was a point that I realized the participants' answers were not presenting new information and the themes emerged seemed to be repetitive. Although considering the heterogeneity of my sample there were still a couple of points that each individual might have mentioned that were not mentioned before but overall it seemed that the saturation level was achieved (Brocki and Wearden, 2006). Therefore, I stopped the process of interviewing I collected data from 23 young people, 11 peer educators and 15 professionals.

#### **4.4. Role of researcher in IPA**

In qualitative research it is accepted that the researcher has a key role in interpreting the data, thus the subjectivity of one's observations is of paramount importance throughout the research process (e.g. Glesne, 1989; Miles and Huberman, 1994, p 6, 26, 29; Fincham, 2006). In light of this, it seems important to consider how my own background, thinking and values might have affected this research study and the interpretations I made of these data. Appendix 7 provides further information on this aspect of the research.

It is important to point out here that it was difficult at times to mix the roles of researcher, reflector and analyser while also trying to be 'in the moment' and follow conversations as they occurred with these young people. I sometimes found myself thinking about what had been said and jotting down notes while the interviewee had

already moved on to another topic. Considering this dynamic process within the interview sessions the value of recording interview data becomes clear..

## **4.5. Process and protocol**

### **4.5.1. Development of the interview schedules**

Originally it had been my intention to use a semi-structured interviewing technique for all data collection, a decision which was based on the IPA tradition and the methodology underpinning of this research, (as well as the assumptions I had made about obtaining data from my target group). However, based on the literature, as well as personal experience of working with similar groups previously, I knew I would not have much time with these young people (also in Griffin, 1998). I also knew that some of them, particularly young men and those from ethnic minorities, would need lots of probing to continue the conversation (Sheldon and Rasul, 2006). As I carried out the interviews with the first few young people, and identified how it had progressed, I knew what areas I would like to cover when talking to peer educators and professionals so I had interview cues prepared in advance. See appendix 2 for examples of these..

I believed that a semi-structured technique would maximise the chance of personal expression for the interviewees. It also is recommended by many pioneers in the field; especially when researching sensitive topics or with potentially difficult target groups. Smith and Eathough (2007; p41-42) summarised these benefits as follows:

“Producing a schedule beforehand forces you [the researcher] to think explicitly about what you think/hope the interview might cover. It also enables you to think of difficulties that might be encountered—for example in terms of question wording or addressing sensitive issues—and to give some thought to how these difficulties might be handled. When it comes to the interview itself, having thought in advance about the different ways the

interview may proceed allows you to concentrate more thoroughly and more confidently on what the participant is actually saying (without being preoccupied by what you are going to ask next).”

I first sketched a very general draft of some open-ended questions that covered the areas under investigation; at this stage I also made use of recommendations from previous researchers. I also read the criticisms of the available research regarding the areas it had covered (such as Ingham and Mayhew, 2006 p 221-222; Macdowall and Mitchell, 2006 ch.10). The next step was to consult my supervisors and read through the literature on interviewing young people and draw upon my previous experiences of working with young people to spot potential problems and devise prevention/management strategies. The final step was to add some probing questions and interview cues for the young people who might experience some difficulty talking about any particular issue. This was also helpful when they found the questions too open, or had difficulties with the wording of questions or preferred to answer in short phrases only.

The interview prompts used for recalling past experiences and stories were based on: *perceived need for knowledge* (whether they thought they had enough resources if they needed them; whether they were equipped with enough knowledge to protect themselves; whether there were areas that they needed more information about); *attitudes towards risk* (whether they thought they needed to protect themselves; if yes, how they did so, and if not, why not); *sexual experiences* (how they saw themselves as sexual beings; their experience of puberty and their current sex lives); and *general questions* about their lives (who the influential figures in life were; what they wanted to be doing in five years time).

I also included several questions which would provide an understanding of the overall context of their lives, including their *thinking, attitudes, and lifestyles* (how they experienced being a young person, what they did in their spare time; alcohol and drug experiences) Finally, I asked them to illustrate a desirable situation for receiving sexual health information that would enable them to achieve their ‘ideal sexual health status’.

At the beginning of each interview I also completed a demographic information form which included questions about age, gender, ethnicity, religion, current relationship status, schooling, work status, family status, living conditions, locality, primary language, English proficiency and immigration status (see appendix 1).

I started interviewing the peer educators and professionals only after I completed the interviews with young people. This may not be considered the usual sequence for conducting research of this kind; which tends to begin with the ‘people in the know’ first and then moves on to the target group in order to contrast or strengthen the comments that were made initially. Because I had identified this research strategy as part of a central problem -i.e. we devise information and policies to meet the needs of socially excluded young people while knowing very little about what those needs actually are; I chose to interview the young people first.

The peer educators who were interviewed were 16-19 years old and were drawn predominantly from the same socioeconomic background as the “hard to reach” young people; the analysis of their demographic information confirms this claim (see table 2). At the same time they also played an ‘adult’ role when it came to providing information for their peers. Because they were able to see the situation from both perspectives simultaneously it was hoped that they might bring a new angle to the study in order to



produce a more comprehensive overview of the situation. Thus, although the peer educators were asked the same questions as the young people. I also asked them to try to respond from both angles: both as a young person and as an educator.

In addition, because peer educators worked directly with many “hard to reach” young people and had first-hand experience of their needs and preferences, I focused many of my questions on their views regarding those needs and preferences and the rationale they could see behind them (for example, what are the most common concerns young people share with them; do they think the sexual health information needs of “hard to reach” young people are different from those of young people who are not so labelled; Who do they think is hardest to reach or is not accessing the information and why?). I also asked them whether they saw any gaps between professionals and young people’s views regarding what they need in terms of sexual health information.

Finally, I asked them about any suggestions they might have regarding how we might reach out to these “hard to reach” groups, who they regarded as the best person to design the information and deliver it, and whether these young people should be approached at all, or simply left alone? They would then be asked to explain the reason behind their answers to these questions. Also, as the peer educators I interviewed had been through formal sexual health training and were affiliated with an identifiable organisation, I went as far as asking them specifically if they thought the training had an impact on any areas of their lives and tried to use my judgement in interpreting their responses in relation to the aims of this research.

The questions for professionals differed from the questions asked of both young people and peer educators (see appendix 2). The general questions about their demographic information were designed prior to interviewing young people and peer educators. However, the more specific questions and areas to be explored were added to their interview schedule only after I interviewed young people and peer educators. I did this in order to have an understanding of what young people might think about their needs and preferences which I could then compare with what I had heard from the professionals.

The demographic questions included age and sex, background, years of experience, job title and responsibilities, and how they became interested in this line of work. This background information proved to be essential in understanding the context of the professionals' thoughts and in the interpretation of young people's needs and preferences.

The professional interviews then focused on the content and the method of educating young people: who designed this information (and on what basis) and whether they had a robust evaluation method to test if it was efficient. I would ask them to compare the information they provide to under and over 16s, between boys and girls, different settings and groups with different cultural, social and religious backgrounds and the reasons behind these decisions. Using these questions, I determined the kind of information needs they associated with young people and the way they thought best to approach them. I would expand on this based on what young people had told me about how they viewed their own needs and preferences. The discussion went on to identify the difficulties of their jobs and the challenges they faced in working with "hard to reach"

young people. I also asked them to recall examples and provide descriptions of specific situations. The interview also included some questions about the needs of professionals in terms of being supported in their roles. By providing an opportunity for the professionals to express their needs I hoped to gain a more comprehensive idea of the context in which sexual health information is designed and delivered to “hard to reach” young people.

Finally, I asked some questions about their views on the role of media and other sources of information for young people, such as the Internet and video games. I also asked them to identify the hardest group to reach for information provision and any possible explanations for this. I finished by asking for further comments or suggestions that they thought were important. Most professionals did provide additional comments or suggestions which are discussed subsequently in the findings sections.

#### **4.5.2. Recruitment and Data Collection**

Three distinct groups were approached and interviewed for this research and I had to use appropriate sampling strategies (mainly purposive and snowballing) for different groups (or for different participants in each group) as will be discussed below.

There were three considerations I had to keep in mind in the recruitment process. First, I had to be realistic about the understandably limited access to “hard to reach” young people, which was incredibly challenging at times; second, it was also necessary to consider the limitations regarding the scope of a PhD dissertation in terms of the time required to conduct, transcribe, and analyse interviews; third, although my research was inspired by phenomenology I had to determine whether I could meet its criteria of putting heavy emphasis on in-depth interviewing techniques (this generally assumes a small sample size and a large period of time in which to conduct the interviews) (Turnpin, *et*

*al.*,1997). Based on these considerations, if I was going to make adjustments I had to think how I could maintain credibility and rigor throughout the study. As far as possible I tried to include a range of young people with different experiences and backgrounds so that I could explore the issues from a number of perspectives which I believed would add to the depth of understanding my research would bring to the topic under investigation.

This research was an attempt to look at individual accounts while considering the social context of the phenomenon under investigation. Moreover it aimed to shed light on our understanding of this particular group of young people, while simultaneously bearing in mind that the group consisted of heterogeneous members. Based on these factors, I aimed to interview a larger number of people during the study. I set out to include a maximum of 30 young people (I actually interviewed 23); 10 peer educators (I interviewed 11) and 10 professionals (I interviewed 15).

#### **4.5.2.1. Recruitment process**

The main approach for recruitment in this research for all the three groups was Purposive Sampling. As Paton suggests, purposive sampling is the most appropriate way of collecting data for interview-based qualitative research that particularly targets heterogeneous and difficult to reach groups:

“Purposive sampling targets a particular group of people. When the desired population for the study is rare or very difficult to locate and recruit for a study, purposive sampling may be the only option.” (Patton 1990, p230).

My first approach was purposive in the sense that I was looking for specific groups to recruit. For young people, I looked for those who were not attending mainstream schools, in training, or employed. For peer educators, I was looking for young people from similar

socioeconomic backgrounds as the first group but who were trained to become peer educators. For professionals, I was looking for those who worked in outreach settings either as the designers or the providers of sexual health programmes.

This worked well with the peer educators and professionals. However, at times I had to rely more on convenience sampling when it came to ‘hard to reach’ young people for two main reasons. First, I did not want to miss any opportunities to include young people who might have met the inclusion criteria for this research. Second, I was aware that recruitment of males would be more difficult than females, thus I made a conscious effort to access as many young men as I could. In addition a snowballing technique - a sub-category of purposive sampling technique - also proved useful for this purpose. This meant I was able to ask the young people I interviewed if their friends might want to take part in the research too (also recommended by Heckathorn, 1997, 2002; Liamputtong, 2007). Also, when interviewing professionals, I would sometimes make enquiries about colleagues in other outreach services that might be interested in participating in this research.

Prior to my PhD I had gained some experience working with young mothers and fathers, which I found very helpful in establishing a good network of youth workers. This was particularly useful considering the fact that the professionals who work with young people in mainstream services and institutions, such as school nurses, are generally not able to access the more marginalised groups of young people. I therefore based my approach partly on my knowledge, the professional’s views as well as existing research with marginalised and socially excluded young people (Liamputtong, 2007, Aggleton and Campbell, 2000).

Another helpful source was colleagues who were experienced in the area of sexuality education and sexual health for young people in a variety of outreach services. I was advised to contact specific places such as youth clubs, job centres, football grounds, sexual health services for young people, and health buses (to name a few) and followed this advice.

My intention was to recruit from as many sites as possible within London, which included the boroughs of Haringey, Camden, Enfield, Brent, Brixton, Tower Hamlets and Islington. London has a diverse population and the chosen boroughs have significant levels of health and social deprivation. Research and the annual reports of sexual health clinics show that young people, especially those from underprivileged socio-cultural backgrounds (including homeless young people) tend to use services from different boroughs (Greater London Authority, 2005; Haringey Teaching Primary Care Trust, 2005). This was one of the main reasons for not limiting my sample to one London borough. Going beyond one borough also increased my chances of recruiting more “hard to reach” young people.

A complete list of agencies I approached for recruitment is listed below in Figure 1. There were also places that I approached but, for unknown reasons, proved unsuccessful in recruiting young people, such as the Leaving Care Team. Based on my previous experience in working with Unaccompanied Minors (Bradford, *et al.*, 2007), I presumed that the youth workers who tried to help me with the recruitment process might not have had the kinds of trusting relationships with young people that would enable them to convince the young people talk to a stranger. I also approached the Kid’s Company, one of the main child agencies/day cares in East London, but they were not

willing to put me in touch with their young people as they believed involvement in too many research projects could be harmful for their groups.

I also went through a thorough ethics approval procedure (a process which took 6 months) that eventually led to an honorary contract with Archway Sexual Health clinic, one of the NHS best-known sexual health services for young people in North London. Yet in spite of strong support from the clinical staff I only had one interview in that setting. The main reason suggested by the clinic's staff was the embarrassment factor; young people wanted to come to the clinic, get the service they need and get out as quickly as possible. However, none of the professionals indicated that they would have preferred their institution's name to remain confidential. However, in this report no names or specifications are used in order to preserve the confidentiality and anonymity of the persons and services who contributed.

Figure 1: Services Approached for Recruitment

Brent Education and Tuition Services (BETS)	A Pupil Referral Unit (PRU). Offering support for education to young people who are not attending mainstream schools for different reasons (most have been expelled).
Archway Sexual Health Clinic	It is a designated sexual health services that only offers sexual health advice and services to young people.
Youth club (in Brent High Street)	These clubs are the places where young people gather to play pool and socialize with each other. There are different clubs for under and over 16s.
Job training Centres (Camden, Islington, Different Connexion services)	These are the places that young people can access information about job, training and housing. They have one off- sexual health workshops for young people and most young people attending are among socially excluded groups.
SHiNE project	Project SHiNE began in 1997 in response to legislation that jeopardised the public benefits of legally immigrated non-citizens. One of the projects involves offering shelter and housing to vulnerable young people.
Kid's Company	Located in South East London, Kid's Company is Charity which focuses on providing practical and emotional support to 'lone children'. They offer training programmes to empower young people in their everyday lives.

Brook Advisory Centres (Euston and Brixton branch)	Brook Advisory Centres is the only national voluntary sector provider of free and confidential sexual health advice and services specifically for young people under 25. Brook is a registered charity, and has 40 years' experience providing advice through specially trained doctors, nurses, counsellors, and outreach workers to over 200,000 young people each year. Brook has outreach as well as clinic based services for young people.
Leaving Care (Haringey)	It is supported by each council and offers a holistic approach to young people's needs, including housing, training, schooling, etc.

#### ***4.5.2.1.1. Young people***

The ways I approached young people for recruitment varied according to the setting.

Generally speaking, at job training centres and similar settings someone such as a youth worker or sexual health nurse would talk to their group about me. I would sit in on their sessions and explain my work. In some groups, mostly the job training centres, I would be given the chance to talk to the group briefly about my research and its goals. I would then say that I would be in the other room if anyone wanted to take part in the research or ask me further questions during the break or after the session. I would also go to talk to them individually in the breaks about general matters and, if possible, explain more about the research to explain my work.

In other settings, such as clinics, hostels or Pupil Referral Units, potential participants would be identified by professionals and asked if they were willing to participate in this project. If they agreed, professionals asked them to verbally consent to being introduced to me. I was then available to talk to participants about the project. For health and safety reasons, and also due to ethical considerations, all the interviews took place in public places, either in my office at the university or in an allocated room in a clinic, job centre or youth club.



Previous research shows that young men are harder to access than young women, because they are more afraid of being judged. Also, they do not want to be told off, some might be afraid to find out about their potential illnesses, and in general they are not accessing sexual health care services as often as young women are (e.g. Edgecombe and O'Rourke, 2002; MacDonald, *et al.*, 2000). I was aware of this issue, as I also found it more difficult to access young men than young women. Some of the young men I saw shied away and left their peer group when I approached them to explain the work further. I did not try to follow them. Instead I used a form of snowball sampling. That is, after interviewing a young person I would ask him to invite his friends to participate if they were also willing. I would also suggest that the interviewee might consider explaining his experience to reassure his friends and to help reduce their anxiety. This proved to be extremely useful and yielded several more participants.

Overall I made a conscious effort to approach young men in groups in order to increase my chance of interviewing them and to keep the research sample balanced. A point worth mentioning is that although the theme of gender differences will come up again subsequently, it was not a main focus of this research.

The use of referrals worked well, whether they came from professionals or peers. However certain issues did arise which would be useful to elaborate. In places where professionals acted as gatekeepers and referred young people to me, especially at the Brent Education and Tuition Services, I had the feeling that the young people who had a good relationship with the referring teacher were more willing to participate and more forthcoming than those who did not have a good relationship with that specific teacher.

Poor student/teacher relationships may have been a factor in my not reaching some pupils.

In cases where young people were referred to me by their friends, they seemed to be more comfortable coming to the interview room, yet most remained unsure as to how much their friend had already told me about them and their sexual experiences. They made comments like: “*Probably X told you that when I was pregnant . . .*”. It was common for young people to ask me not to share certain parts of the interview with their friends who would be interviewed next. To prevent this assumption from interfering with their responses, I attempted to assess the closeness of the relationship by asking them how well they knew each other. I also explained that I would only ask each person about his or her own life. I hoped that this would encourage them to share important information with me.

However, the snowballing technique had other disadvantages as well. Because it required one person to refer another to me, I might have missed certain young people who were truly isolated and not in touch with many people in society; including their peers. Because of the lack of resources (for example a back-up researcher) I could not possibly put myself in potential risk by going to the street, gang gatherings, or other places where I might have had more access to more marginalised young people. At the same time I do feel that the voices of socially marginalised young people were heard through this research - some of whom seemed to have only one or two acquaintances in their lives.

All of the young people I interviewed were between the ages of 14-20 and were not attending mainstream schools. They had either left school (at different levels) or had

joined BETS. Young people over this age, and those attending schools, were usually excluded. Eight currently lived, or had been brought up, in a single parent family, mostly with their mothers (n=7). One had been brought up in a foster family, two lived around with friends and did not have any permanent abode, three lived in a housing project, and two lived on their own in council flats. A further seven lived in a household with two parents (either with their own parents or a step-parent). (See Appendix 5).

#### ***4.5.2.1.2. Peer educators and Professionals***

Peer educators were recruited through outreach services, mainly Brooks Advisory Centre and Connexions.

Professionals were recruited through the various agencies and settings where they worked, such as outreach services, young people's sexual health clinics, Pupil Referral Units and organisations which were directly involved in providing sexual health information to young people outside schools, such as Brook's and Barnardo's. I also used a snowballing technique for professionals.

### ***4.6. Interview process***

#### **4.6.1. Group One: "Hard to reach" young people**

I interviewed 12 girls and 11 boys in this group. Special attention was given to keep the gender of the participants balanced.

When I met the potential participants I would introduce myself, if I had not done so already, and would tell them about my research in the context of my degree. I would then explain the subject of my research and the importance of their contribution.

Following this, we attended to the practical matters that needed to be addressed before

the interviewing began. First was the confidentiality and anonymity agreement that made them aware of the voluntary nature of their participation. At this point I would also have a brief discussion with the under-16s to make sure they met the competency level outlined in the Gillick guideline<sup>2</sup> prior to the interview (Wheeler, 2006). I also gave each participant the telephone number of the university in case they had any complaints about the way the research was conducted. I then asked them to read the information sheet that explained the research in a written format (appendix 3) and to read the informed consent form (appendix 4). I insisted that they read it through before signing it.

One of the potential problems I had anticipated at this stage was that some of the young people might have low levels of literacy and be unable to understand the information in the consent form. To prevent this problem, I explained the process of research verbally as well to all young people and answered any questions they may have had before starting the interview.

One area of concern for obvious practical reasons was language proficiency both from my side (not being familiar with the young people's jargon) and from the young people's side (in case of their lack of English proficiency). Luckily, overall I did not have any problems communicating with the interviewees, possibly because most of them had to have a certain level of confidence in their language skills in order to agree to the interview in the first place. It is possible I might have lost some young people who were not outspoken or not fluent in English to this fact. Some did speak languages other than English at home (for instance, YPs 02, 03 and 04) and two girls who were Iranians used mixed language (English and Farsi) during the interviews. As I am a native Farsi speaker

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<sup>2</sup> The standard is based on a decision of the [House of Lords](#) in the case *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL).

this was not a problem. The remainder were brought up in the UK or had enough proficiency in English to convey their thoughts.

At this point I asked each interviewee to pick a nickname if they did not want to be interviewed using their real names. Before starting the tape recorder, I also went through their feelings about taking part in this research and what made them do it, and I expressed my own appreciation to them for sharing their thoughts and experiences with me. Finally, after checking details with them, I filled out a demographic form for each participant (Appendix 5).

With the tape recorder switched on, I began asking some general questions such as where they live and what they do in their spare time. I then moved on to more specific topics such as the first time they received any form of sexual health information, how they felt about it and so on. I made occasional notes, but tried to concentrate on what they said to ensure that I asked follow-up and probing questions. Before starting the interview process I had rehearsed the topics so that I could facilitate the interview process, ensuring that it ran as smoothly and non-mechanically as possible.

When interviewing certain participants, particularly the young men, I had to use probing questions or interview clues because they were happy to respond with short answers. Some of them might also have found a question too broad, so I needed to point the topic a little bit to give them a chance to focus and to make it easier for them to follow the flow of the conversation.

Based on my previous experience I had anticipated that some young people might get embarrassed or uncomfortable talking to a stranger about their personal lives. To minimize this effect, the interview sessions were held in conversational manner.

Although I did have a set of prewritten questions, I tried not to use them as such—that is, I did not go down the list and check off each question after it was asked— so that I would minimize the feeling of being interrogated as much as possible. The questions were not very personal in comparison to some of the other research around sexuality; for example, I did not ask them to tell me about the time they lost their virginity.

I believe my counselling background and experiences working with young people helped me to keep the interviews running smoothly. I also sought professional advice from the gatekeepers (where one was available) on how to approach the individuals they had referred to me. I was especially aware of asking beforehand if the young person had a history of a mental health condition that I should be sensitive to. I also took advantage of literature about doing research with people who are at the margin of the society and are excluded from some aspects of the community (Liamputtong, 2007).

Early on in the research I realised that if the young people thought of me as an authority figure who was only there to ask them questions and get information from them they would try to keep their answers as short as possible. This was true of the peer educators and professionals as well. This was especially the case in BETS, where there was a fear of disclosure to the school's administration, and in the asylum seeker group, where there was a fear for their status. However, by allowing them to ask questions about my background, such as how I got involved in this research as part of my degree, and also about different aspects of their own involvement, I believe I gained their trust. My feeling was that if they saw the interview as a conversation, rather than an interrogation, they would tend to share more of their original views and less of what they thought I would expect them to say. I believe this was the case.

Most of the interviews were conducted without interruptions, except for one in a job training centre where the youth worker interrupted the session twice to make sure everything was alright as I was interviewing a troubled adolescent who had difficulty concentrating and had problems with drugs. At BETS the teacher had to interrupt one session twice because the pupil had to be provided with lunch while talking to me. And on one occasion the interview was stopped and I had to go back to finish it because the pupil wanted to skip her class to take part in the interview. I was not aware of this but luckily the teacher who introduced this young person to me in the first place noticed her absence and came to get her. There was also an occasion when I did not finish an interview because the young person had to go to lunch and I could not find her again. I excluded this interviewee because we only went as far as completing the demographic information form.

All the interviews were recorded with the exception of one, a young man who was afraid if the interview was taped the information might be divulged in a way that would affect the prospect of his application for citizenship. I only took notes for that session.

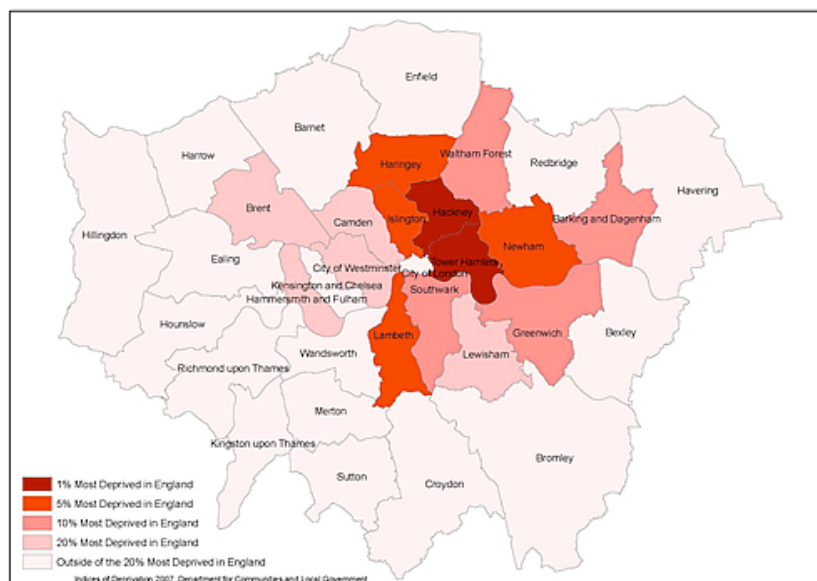
As indicated in other research guides (Smith and Eutough, 2007; p44), interviews of this nature tend to take a minimum of one hour. In this study, however, interviews with young people lasted from 60 to 90 minutes. Some took longer when the young person was willing to share more whereas some took less time especially with boys who tended to respond in short phrases. For the peer educators usually the interview session took longer as they tended to be more opinionated and articulate in comparison to the ones in the “hard to reach” young people group.

After the interview was finished, I asked them if they had any questions and whether they wanted to receive a copy of their interview transcript or the overall research results. If the answer was positive, I asked for their e-mail addresses or contact details so that I could send them the material. I sent the interview scripts to young people who provided me with their e-mails or addresses. Overall, thirteen young people wanted to hear the report of the research; five provided me with their e-mail addresses, two asked me to send the transcripts to their friend's or girlfriend's e-mail and mailing addresses, four asked me to send the transcripts to their sexual health teacher at the Pupil Referral Unit (PRU) (but in a sealed envelope), and two asked me to post it to them. The rest did not want to be contacted to review their transcripts. I tried to contact all the young people who showed interest but have not heard from any of them. This could be due to the time gap between the interview session, and preparing the transcripts to send to young people.

#### **4.6.1.1. Characteristics of the sample: Young people**

Interviewees were recruited from variety of settings and geographical locations within eight boroughs in London. The map below shows the recruiting sites for young people and peer educators:





### Sites of Recruitment for Peer Educators and “hard to reach” Young People

In total, a diverse group of 23 young people took part in the study. They were aged between 14 and 20, with a median age of 16.5, and consisted of 11 males and 12 females. The main inclusion criterion for young people was to belong to one of the socially excluded groups, mainly by not being in mainstream education, employment or training (NEET). At the time of interviews there was one young person who mentioned that she was at college and another one was employed, however these two were not excluded because of their relevant life experiences.

Most of these young people had patterns of interrupted schooling and had not attained any qualifications due to drop out. Three young persons who immigrated to the UK as young children did not have records of any formal education in the UK, though all explained they were at school before emigrating. Some of the remaining young people were in the process of getting into a Pupil Referral Unit. Seven indicated that they left school before 16 (Table 1). Fourteen had attended mixed-sex schools and four had

attended single-sex schools before discontinuing at different levels. One had never received any formal education and was instead taught by members of his family.

Ratings on a five-point Likert scale of level of religiosity in the demographic information form (where 1 was “not important at all” and 5 was “very important”) indicated that six young people scored 4; four scored 3; five scored 2; two marked 5; and six marked 1.

**Table 1-Basic characteristics of young people**

	Young people (number), N=23
Age	Under 16 (10), over 16 (13)
Gender	M (10), F (13)
Highest level of education	High school dropouts (12), High school (8), A level (2), no education (1)*
Ethnicity	White British, White other (3), White Irish (2), Mixed race (3), Black Caribbean (5), Black African (5), Asian-Bangladeshi (1)**
Religion	Christian (11), Muslim (8), Jewish/Christian (1), None (3)
In Training	Yes (0), No (19), 4 young people attended a job training programme on and off at the interview venue
In Education	Yes (4), No (21) from which 7 just started in a PRU
In Employment	Yes (1), No (22)
In a Relationship	Yes (9), No (12), on and off (2)
Immigration status	British citizen (18), International student (1), recent citizen (1) Asylum seeker (2), No official status (1)
Who they live with	Both parents (6), step parents (1), single parents (10), other young people in a housing project (2), between friends (2), alone (2).

\* Seven of young people just joined a PRU and were dropouts from mainstream schools.

\*\* For the purpose of this table the categories used are in accordance with the ones provided by the National Office of Statistics. Ethnicities based on young people’s subjective views will follow below.

For the purpose of clarity, in the analysis I group the ethnicities based on the national categorisation of ethnicities (table 1). However, the way young people viewed their ethnicity seemed to have a correlation to their perception of their place in society, therefore it is useful to include the exact wording they used in describing themselves. The

interviewees saw themselves as coming from a variety of backgrounds. Two identified themselves as “black African with Somali origin”, one as “black-Somalian”, one as “black-Eritrean”; one as “black-Angolan”; two as “white-British”; one as “Asian (Bangladeshi)”; one as “white-Irish”; two as “black-British”; two as “Iranians” (one had been raised in Sweden); one as “Turkish”; and two as “black-Caribbean”. Seven further identified themselves as being of mixed race, including two “black-British”; one “Portuguese-English”; one “Caribbean-white”; one “English-Irish”; and two “Caribbean black-white”. This will be discussed in the following sections. (Please see appendix 5 for complete demographic information of young people).

#### **4.6.2.Group Two: Peer Educators**

I interviewed 11 peer educators, 5 male and 6 female, working with Connexion, Brook Advisory Centres and 4YP (For Young People). This group included young people between the ages of 14 and 16 who were engaged in educating their peers about sex and relationship matters in different outreach programs. Peer educators were mostly recruited through the Brook outreach services and only a couple were through other sexual health services (such as Kilburn teenage pregnancy team). Nine were either attending college or waiting for the term to begin their studies, and two were not in education. The process of interviewing was exactly the same as that mentioned above for the socially excluded young people. However all the peer educators were referred to me by professionals.

It was hoped that this group would add richness to the research data, as they were both young and at the same time involved in the adult act of educating their peers. Hence the prompts I used, the nature of which was described above, included questions that were uniquely suited to this group.

Peer educators were mainly recruited from the outreach services where they worked. They were recruited to these services by responding to a poster at a local cinema, youth club, or similar venue. They then went through a training programme that prepared them to act as peer educators. Their everyday work involved going to pre-organised sessions to deliver sexuality and relationship education to their peers. On my visits to the Brook centre (all but one peer educator came from Brook), the peer educators seemed to have close relationships with one another, and supported each other in times of need. Because they delivered their sessions in pairs they were also seen as colleagues.

#### **4.6.2.1. Characteristics of the sample: Peer Educators**

Table 2 shows the summary of the peer-educators demographic information:

**Table- 2 Basic characteristics of Peer Educators**

	Young people (number), N= 11
Age	16 and under (4), over 16 (7)
Gender	M (5), F (6)
Highest level of education	High school dropouts (1), High school (9), A level (1), no education (0)
Ethnicity	White British (1), Black Caribbean (4), Black African (6)
Religion	Christian (10), Muslim (),None (1)
In Training (apart from youth work)	Yes (0), No (11)
In Education	Yes (5), No (6)
In Employment	Yes (4), No (7)
In a Relationship	Yes (5), No (6)
Who they live with	Both parents (10), one parent (1)

It seems significant that the peer educators did not tend to think of themselves as “one of them”—that is, “hard to reach”—although most were from similar socioeconomic backgrounds. This was made clear both in the peer educators’ comments and also in terms of the differences in how the two groups imagined their futures. Also significant is

the fact that the vast majority of peer educators lived at home with both parents. Thus the extent to which they can be considered peers in the true sense must be questioned.

#### **4.6.3.Group Three: Professionals**

15 outreach sex and relationship youth workers, nurses, teenage pregnancy coordinators and curriculum developers were interviewed using a semi-structured interview schedule.

I interviewed 4 males and 11 females in this group; age range was between 23 and 54.

As mentioned above, these individuals were recruited in the places where they worked, and also by using a snowballing technique. Among this group, I also interviewed two professionals who were responsible for developing and disseminating sexual health curriculum and programmes to different services. One was from a Governmental body and the other was from an NGO which is involved in working with socially excluded young people on a variety of issues including their sexual health. My aim was to obtain their expert views about the most effective and favourable way sexual health messages might be delivered to the socially excluded young people. At the beginning of the interview, each participant was also asked to complete the demographic information form (appendix 1). All the interviews took place in the professionals' offices or places of work. See Figure 2 for a list of the professionals interviewed.

Figure 2: Sites of professionals' interviews

1	Health improvement specialist, young people health bus
2	Brook Clinic sexual health outreach worker and co-ordinator
3	Sexual health and relationship youth worker and outreach worker
4	Sexual health education outreach worker
5	Barnado's men service, children service managerial post (also responsible for design of the material)
6	Teenage pregnancy team coordinator for three inner city boroughs (also responsible for design of the material)

7	Sexual health outreach nurse
8	African Child Charity, coordinator for Brent, Harrow, Ealing, Hounslow
9	Manager, one of the Sexual Health Clinic for young people
10	School nurse
11	School nurse
12	Manager, of a Leaving Care team in inner city London
13	Iranian Association; head of family and women section
14	Chairman and CEO of the of a media company (producers of educational website material for adult) also a text messaging service providing sexual health information to young people.
15	Sexual health service co-ordinator

Professionals were happy to be acknowledged in the research and all consented to having their quotes and comments be used together with a mention of their organisational post. For purposes of anonymity, exact locations are not divulged in this research, though organisational posts are listed. I checked this with them at the time of interview, as some of the comments might not make sense if the reader were not aware of the interviewee's position.

Professionals were asked if they would like to see their interview after it was transcribed. All were positive. After sending their transcripts, three had changed their work places, one was on maternity leave and the rest came back to me with more questions (such as when the full report would be ready) or with some updates about their services. I intend to send a brief summary of the report to all of the professional contributors as part of disseminating the research findings and bringing them to the attention of practitioners and policy makers.

Furthermore, although this research made use of a semi-structured interview technique to collect the overt data, as a qualitative researcher I also had to take notes and pay attention to the 'covert' data that was projected from each interviewee without necessarily being stated aloud. For example the body language, the off-record

discussions, the journey I took to find that individual, and so on. These records are presented as a part of the analysis chapter to help put the findings in context.

#### **4.6.3.1. Characteristics of the sample: Professionals**

The professionals who acted as sexuality and relationship advisors and workers, or who were involved in designing information for young people, came from a variety of backgrounds (Table 3). Some had higher education degrees while others entered the field with no formal degree and went through hands-on training. They continued attending training courses as they progressed with their jobs. Majority of the professionals, especially the youth workers, identified with the demographic background of the young people in this study and several of them still lived in deprived areas of London.

**Table- 3 Basic characteristics of Professionals**

	Professionals (number), N= 15
Age	Average
Gender	M (4), F (11)
Education level	High school dropouts (1), High school (2), A level (1), higher education (11), no education (0)
Ethnicity	White British (2), White other (4), White Irish (2), Black Caribbean (4), Black African (3),
Religion	Christian (11), Muslim (2), None (1), Buddhist (1)
Years of outreach experience	Less than one year (8), between 1 and 3 years ( 1 ), more than 3 year (6 ).

#### **4.7. Transcription**

The tapes were transcribed verbatim using a transcribing machine provided by the university. I started this process after completing the interviews from fall 2005; the last one was transcribed in March 2008. On average, each tape took between five and seven hours to transcribe depending on the length and the quality of the tape. The transcripts were typed using Microsoft Word and they were named according to the category of the

interviewees and their names (or nicknames) (see appendix 8 for a sample of a transcript, individual profile that was made for each participant and the main themes extracted from the sample interview). The tapes were kept in a safe place.

## **4.8. Data analysis**

### **4.8.1. Thematic Analysis**

Although the individual accounts were vital to this exploration, the area under investigation encompassed more than one person's experience alone. Rather, the research focused on the social construct of the individual's perception of needs regarding sexual health information, and the ways in which those perceptions influenced their experience of acquiring sexual health information. Thematic analysis of the text seemed to be the most practical and feasible way of analysing the data for this research, as the data were not detailed enough to follow the interviewees' accounts in a more narrative, case study style (Smith and Eatough, 2007; p 45-49; Storey, 2007). Therefore, in order to make the best use of the data this research utilised thematic analysis of the interview texts to extract the common patterns and themes (in agreement with IPA and its emphasis on human experience).

### **4.8.2. Triangulation of the Data**

After the themes for each group were extracted, I compared the views of the three groups on each topic. In another words, instead of having separate chapters to present the themes emerging from each group's transcripts, I discussed themes extracted from all three groups perspectives (please see the findings chapters). To make the comparison and contrast among the groups more distinct and systematic, I used Denzin's (1970) frame of work for "Data Triangulation". Denzin advises that in order to understand a social



phenomenon it should be studied from the perspective of people who are involved in that phenomenon and how their lives are affected by it. Also, because I chose IPA as my method of choice for data analysis, it was the perception of each group regarding the sexual health information needs of young people that formed the triangulated perspectives.

As mentioned earlier the interviews with all three groups transcribed verbatim by myself. While I was transcribing/typing the transcripts, I would note any ideas, questions, or thoughts that came to my mind in the text in different colour. I also highlighted any potentially significant points.

#### **4.8.3. Analysis of the data step by step**

The **first step** of the analysis was to read each of the transcripts thoroughly at least twice. This included any field notes or other notes I took about that specific person (they were attached to the demographic forms and coded per person). As recommended by Smith and Eatough (2007; p 44), and Storey (2007), while reading I wrote down any keywords and phrases that sounded significant to me, considering the aims and objectives of this research, in the right margin. These would then act as reminders for me to know what prompted the final themes. I paid close attention to the patterns of speech, contextual matters and specific terminologies used to describe the needs and preferences. I also tried to capture the attitudes and feeling of interviewees when telling a story or answering a question. I incorporated them later in my analysis when describing the context of the main themes.

In the second reading I looked for any emerging themes or phrases. I was adding my interpretations and thoughts to the keywords as well. However; as advised by Smith and Eatough (2007; p45) I had to take care not to lose the connection between the interviewees' own words and my interpretation of what had been said. To prevent this confusion, I used the left margin of the text to write down my ideas and thoughts. I also added the field notes to the right margin of the text where appropriate. To conduct a cross check, I then used WordStat 5.1. This software is developed for qualitative research data where a large volume of text is available. It has the capacity to list the words used in the interviews by frequency. This was helpful in making sure I did not miss any themes or words that were frequently used by the interviewees. By the end of this stage I had the main keywords and phrases, and my interpretations of them, in a more organised and accessible way.

The **second step** was to read the transcript a third time in order to establish the connections between the preliminary themes and cluster them appropriately. I created one box for each interviewee where the main themes and concepts were presented.

Once these two steps were carried out for every single individual in each group, the theme boxes were ready for the **third step**, *cross case analysis* (see Smith and Eatough, 2007). At this stage the common themes were extracted; some were dropped because of lack of relevance and others because of lack of depth in supporting evidence and narratives. When discussing these themes in the findings chapters I provide examples of quotes and stories that support each theme, and compare and contrast them according to the role and characteristics of the interviewee.

From this point forward, when the triangulation came into the picture, I began with the thematic analysis and the cross group/theme analysis (Smith and Eautough, 2007; p47). For this, I used the correlation feature of WordStat 5.1 to show the links between the main themes that emerged from each group and checked for any cross-links between themes that I might have missed in hand analysis.

The adapted analysis method of this research allowed me to look at each interviewee both as an individual and as a part of his/her group. At the same time, it facilitated clustering them as one group in a study of three groups. Ultimately they all joined each other like pieces of a jigsaw puzzle, enabling me to engage in a discussion aimed at describing their positions as members of a bigger society who might potentially attain different understandings of the same phenomenon.

#### ***4.9. Advantages and limitations of the chosen methodology***

Although several different qualitative designs were potentially valid and applicable to this research, there were a few aspects of this research that made qualitative semi-structured interviewing the method of choice, i.e. pragmatic considerations, confidentiality issues and the importance of personal accounts and verbal expressions. The key advantage of using interviewing techniques are their ability to collect rich and detailed data from knowingly “hard to reach” young people who might not normally participate in surveys and more formal types of studies. Most people like to talk, share their experiences and tell others what they need and prefer (Rubin and Rubin , 2005), and an interview with open-ended questions is suggested to capture such views. Also, this

method gave me the opportunity to elaborate on points that needed more discussion (Maxwell 1996; Kvale, 1996).

However, when I found that some young people find it difficult to understand the open ended questions or to engage with them and at times I thought it might have been better to have more closed and structured questions. However, I doubt whether the data I would have collected with that method would have been as rich. In the end, I went back to thinking that a semi-structured interview technique was most appropriate for this topic. A semi-structured approach also provided sufficient structure to ensure that the research questions were addressed in a logical format for the interviewee, but also had enough scope to explore the underlying contexts and meaning and detailed understanding (Bryman, 2004, p 319). As mentioned earlier, some of the participants had difficulty focusing on the discussion. A semi-structured approach provided them with a framework and at the same time gave them the liberty to be flexible within that framework to express their opinions and views freely (Commission for Social Care Inspection, 2007).

The main limitation of collecting and transcribing the interviews is that it is very time consuming. Each hour of taped interview required up to seven hours of transcription and about the same time or more for analysis. The transcription was made especially difficult because of the sound quality of the interview setting, which was sometimes poor. One such interview was conducted while road work was being done outside the window, yet I did not want to postpone the interview for fear of losing the participant. The combination of hand analysis and using textual analysis software was a new experience for me that was challenging at times but rewarding at the end. It took me a few weeks to explore the software's many functions in order to be able to create a search strategy

within the text that would provide a thorough account of the words and their interpretations. Therefore, the trade-off for having rich qualitative data was the time required for its collection and analysis.

#### **4.10.Credibility**

Credibility is a criterion that mirrors internal validity (Bryman, 2004) and two of the best techniques to ascertain credibility are respondent validation or member validation (Bloor, 1997, 2001) and triangulation (Denzin, 1970). For respondent validation, I had to give the transcripts, my analysis or the summary report of my research to the interviewees to verify the credibility of the narratives, themes and conclusions. However, as mentioned before my attempts to contact young people after the interviews were not successful. Therefore, I used my supervisors' as well as other expert's views to review the analysis and provide feedback on my approach and improve the credibility of the results. Another way that I worked on the credibility criteria was to submit different segments of my research to several high-standing conferences and present to an audience with relevant expertise and knowledge. Their questions and reflections after my presentations were regarded as colleague validation for my results.

I have also chosen three groups to interview as a method to triangulate my results (as previously done and recommended by Miles and Huberman, 1994, p266), which can significantly improve the credibility of the research (Boyatzis, 1998, p182).

#### **4.11. Transferability**

Transferability is parallel to external validity, which was described in detail by Lincoln and Guba, (1985). They suggested that in qualitative research, using ‘*thick descriptions*’ could improve the transferability of results to other contexts and settings. The reason is that having a more detailed description of cases and contexts can help the generalisation of the results when dealing with similar settings and contexts (also in Guba and Lincoln, 1994; Geertz, 1973a). In my research, I made every attempt to provide a rich description of young people’s lives, their stories, their challenges and experiences, and I analysed their decisions and choices, linking them with broader contextual matters such as recent sexual health policy.

#### **4.12. Dependability**

Dependability mirrors reliability in a qualitative research and one of the techniques that improves this aspect is working on the research governance matters and creating auditable processes of data collection and analysis (Lieblich, 1998). The more transparent the research to peer review, supervision and auditing, the more dependable will be the results (Lieblich, 1998; Riessman, 1993). Therefore, one can argue that a doctoral level dissertation in general is a highly dependable document as the methodologies are discussed in great detail and the protocols, transcripts and analyses are conducted under close supervision.

#### **4.13. Confirmability**

This criterion parallels objectivity and as described by Guba and Lincoln (1994):

*“... is a matter of not allowing researcher’s personal values; prejudices and impressions from other studies influence her interpretations in a way that would be different from other people’s interpretation.... in other words, if two independent researchers analyse a set of qualitative data, their conclusions and extracted themes should not be that much different.”*

The first part of above-mentioned quote could be considered most important in this research since in one to one interviews there is always the danger of leading the interviewee to the direction that one aims for (this point has been recognised by many researchers for example in works of Berg, 2001 and Hood, *et al.*, 1999). From that point of view, being objective and not imposing ideas and thoughts on the interviewee matters a great deal. I tried to meet this criterion by using a semi-structured interview schedule, via the format of open-ended questions, and by giving the participants the chance to express themselves in whatever way they desired.

However, the second part of the quote is less relevant to this research, as it was informed by IPA, which implies that the researcher's perception, background and way of thinking matter greatly in all the steps of the research. As explained earlier, my background came to play an important role in the whole process of this research from choosing the research questions to conducting the interviews. Most importantly my personal thoughts and experiences are reflected in the analysis section of this research.

#### **4.14. Conclusion**

This chapter began with a presentation of the theoretical underpinnings of the research methodology. It went on to discuss my own personal background and the influence that may have had on the data collection. It continued with a detailed description of the processes and protocol of the research. Ethical considerations were addressed, followed by a detailed description of methods for data analysis. The final section addressed some of the advantages and disadvantages of the chosen methodology, and discussed issues of credibility in terms of transferability, dependability, and confirmability. In the chapters

that follow I will now provide a detailed account of the themes that emerged in this research and that help explain the experiences of these young people and their sexual health.

#### **4.15. Ethical considerations**

##### **4.15.1. Working with “hard to reach” young people**

Existing literature acknowledges specific ethical issues and problems of access that could arise when working with young people (Wiles, *et al.*, 2006; Munford and Sanders, 2004). These considerations are of greater magnitude when one is working with particularly vulnerable young people, including socially marginalised ones, or individuals who are not known to have reliable social support to protect them against the discomfort or even harm that might arise from participating in such interactions.

Throughout the interviews I relied on my experiences as a counsellor working with both mentally disturbed individuals and vulnerable adolescents. I took special care to curtail the influence of any negative factors—such as fear, confusion, shock, fatigue, false assumptions and misinformation—by facilitating and emphasizing the voluntary nature of participation. Participants were informed of their right to withdraw from the research at any time, with no questions asked. In addition I provided enough information about the research to allow them to clarify the research and its process (Kvale, 2008).

When dealing with young people under the age of 16, the professionals who referred them advised me as to whether they satisfied Gillick competence and were thus eligible to participate. In the process of explaining the research, I checked their mental



capacity as well. They had to be capable of understanding both the topic and their own situation, and they had to be able to give sensible answers to the research questions.

As mentioned earlier, both confidentiality and anonymity were stressed. Participants were given an information sheet and I also talked to them about confidentiality and the use of information in case they had difficulty reading the notes. They also had a phone number to contact in case they had any complaints about the way the research was conducted. Each participant was told that all the information they provided would be treated in confidence. It was emphasised that this meant that the information would not be released to other people, such as their doctors, nurses, parents, teachers, or other professionals, without the participant's consent. They were however aware that this confidentiality contract would terminate if a young person disclosed an abuse that was likely to endanger his/her life. In such a case I would have needed to discuss the case with my supervisor and take her advice. There was only one occasion when this arose—a 19-year-old girl disclosed a sexual assault by her stepfather when she was a little child. I provided her with the information necessary for her to report the perpetrator to the relevant agencies and to prevent future harm from him to other children at home. I also consulted with my counselling supervisor and took her advice on the case. As the father of the 19 year old was no longer around (her mother separated from him some years ago), the mere reporting of this to the agencies was sufficient.

#### **4.15.2. Ethics committee approvals**

There were two ethics committee approvals for this research; the first was from Middlesex University Research Ethics Committee (REC) and the second was from the Camden and Islington Research Ethics Committee. Both approvals required a

considerable amount of form-filling and paperwork and the second (LREC) proved to be very time consuming as well. As I needed to access some young people attending sexual health clinics, they were considered to be NHS patients and the university REC approval was not considered sufficient proof of ethical adherence for the research. The age range of my target population was another factor, as I also intended to recruit from the under-16s age group. Very little previous research had looked at that age group, perhaps because of the difficulty of obtaining REC approval for this type of research. An interesting observation was that when I was called in to one of their meetings all their questions and concerns seemed to be around my own ethnicity and use of language on the information sheet. No concerns or questions were actually raised around the ethical aspects of the research.

#### **4.15.3. Risk management**

In order to minimise risk during the process of this research all the interviews were done in a public setting. Where appropriate, I was given an alarm by the youth worker so that I could notify them about any dangers or possible assaults. I also always carried a mobile phone. I did not carry much cash or too many vouchers for interviews. I completed Police Clearance (CRB) as it is required for working with young people. I also completed Middlesex University's risk assessment form. Arrangements were made with professionals to have a room available for the interviews in the clinics, youth clubs and other venues. This was to interview young people in privacy while benefiting from the security of a public place.

I was advised that some of the young people might be mentally distressed and I had to stay calm if they suddenly started to walk around the room, could not concentrate

on the topic, or needed to smoke between the sessions, etc. I found my counselling background and my experience of working with mentally distressed adults useful for feeling at ease in such situations. I felt quite safe during most of the interviews and did not feel any particular danger or risk from the interviewees.

## Chapter 5- Findings: Descriptive and Interpretive Themes

### 5.1. Introduction

This chapter will introduce the main areas of need that emerged in the interviews with each of the three groups: “hard to reach” young people, peer educators and professionals: *Need for Information*, *Need for Help*, and *Need for a Significant Other*. It will go on to introduce the six themes that emerged from the interpretive analysis of the data collected. The first three, which include *trust*, *reliability*, and *comfort*, concern the acquisition of information by young people. The second three, which include *accessibility*, *helpfulness* and the *quantity and quality* of information, concern the provision of sexual health information.

The research data is supplemented with demographic information for each individual, which was obtained from forms that were filled out at the beginning of each interview. Additional information was provided from my own observation notes. Taken together, this information paints a picture of the histories of these young people, and gives an understanding of the context of their lives.

### 5.2. Extracting the main themes from the data

In order to draw out the main themes that arose in the interviews, the data was analysed at two levels. The first level was a descriptive analysis of the data based on the interview transcripts. For this all the data was coded using WordStat, an advanced qualitative data analysis software. The resulting information was helpful in making sure that all of the high-frequency words and patterns were included in the analysis. It also proved useful

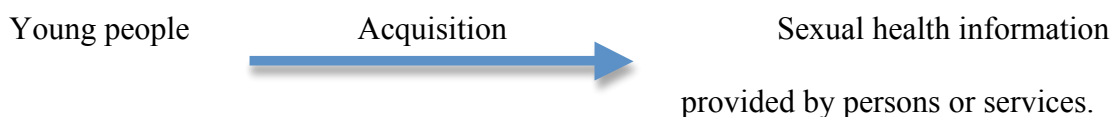
when exploring each interview in terms of the life-context and background of the interviewees. For example, there are subtle differences between wanting “. . . some one *to tell* me what to do”, “. . . someone *to discuss* my questions with” and “. . . someone *to ask* my questions from” which were only brought to my attention after I drew the table in Appendix 6.

In the next stage a more interpretive approach took place where the transcripts were reviewed again in order to search for any correlation between young people’s background and the way they presented their needs and preferences. For instance, in the example mentioned above a link emerged between the cultural background of the young person and the way he/she expressed a need for information. The importance of social context was evident and played some role in determining whether they wanted someone *to tell* them what to do, *to discuss* their questions with, or *to ask* information from.

Finally, examining word frequency was useful when it came to comparing the three groups’ ways of expressing their views about the same topic. Because many young people lack knowledge of the explicit and direct terminology used by professionals, the number of citations of a given word is not necessarily indicative of the importance of a theme for a specific group. However the choice of words and the implicit meanings they were trying to convey nonetheless illustrated their knowledge of certain concepts. The diagram below is a summary illustration of the main concepts and themes that emerged from the data, which included interview transcripts and other data collected:



Chapter IV, which follows, will discuss the three areas of need that emerged in the descriptive analysis of the data: the *Need for Information*, the *Need for Help*, and the *Need for a Significant Other*. This will be followed by an interpretive analysis of the data, which revealed six additional themes that relate to the needs and preferences of “hard to reach” young people. Chapter V will explore the factors that facilitate or impede a young person’s ability to acquire the information, rely on it, and take it in, which include *trust* towards the system which provides the information; the *reliability* of the provider and information from young person’s perspective and the level of *comfort* the young person feels in accessing the information, including feeling comfortable with the person who provides the information.



The second group of themes address the provision of the information in terms of whether or not it reaches the young person and is seen a useful and relevant. In this section the *accessibility* and availability of the information, its *helpfulness* and relevance to their lives, and the *quantity and quality* of the information will be discussed.

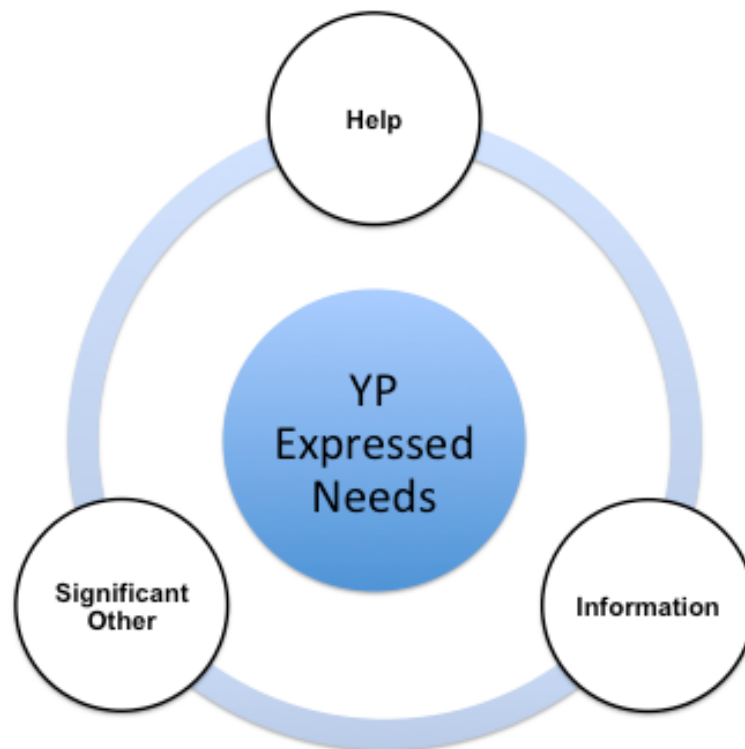


The discussion that follows is an attempt to fulfil the objective of this research: to increase our understanding of the sexual health information needs of “hard to reach” young people by looking at the construct of the problem rather than attempting to solve it. It is hoped that by challenging some of the preconceived assumptions that currently exist in the literature, and exploring the situation from this fresh perspective, we may come to a better understanding of the needs of a group of young people who have not been heard.

### **5.3. Main themes emerging from the descriptive analysis of the data**

This section introduces the main areas of need which emerged from the interviews with each of the three groups: “hard to reach” young people, peer educators and professionals. Though it will concentrate on the young people’s views, some relevant comments from professionals and peer educators will also be included under each section (instead of being presented in separate chapters) in order to show how their views are in accordance with or opposed to those of the young people, or how they complement the views of the young people in a more general way.

The expressed needs that emerged from the transcripts fall into three general categories: *Need for Information*, *Need for a Significant Other* and *Need for Help* (see Figure 1).





As might be expected, these categories are interrelated and intersect with one another at many different points. An expressed need for information might also include an implied need for a significant other to provide that information; alternately, a need for information might in fact be a need for help with a specific problem. Though it was sometimes difficult to locate individual needs within these categories, they did provide a useful and important overall structure for analysing the data from the interviews.

Based on descriptive analysis of the data, needs emerged which were both explicit and implicit, eloquently articulated or unarticulated yet clearly implied. Sometimes, particularly for young people who might for a variety of reasons not identify a need or have the language to express it, I assumed the nature of the need based on the information that was provided by them or by the two other groups. I took caution in doing this, however, and always remained mindful that the purpose of this research is to give young people a voice.

As has been stated, the main focus of the research was to explore young people's perceptions of their need for information related to their sexuality in general and to their sexual health in particular. Each person interviewed was aware of the focus of the research from the beginning, thus any discussion of needs might be assumed to relate to the concept of sexuality. However, as the interviews progressed it became clear that many of the young people had other needs—for housing, money, help or protection—that eclipsed the need for sexual health information. Because life context is an important consideration in any attempt to understand the needs of “hard to reach” young people, these other needs will also be included in order to paint a more complete and nuanced picture of their perceptions of need for sexual health information.

The sections that follow will explore the three areas of ‘need’ as expressed by each group: the nature of the need, the perception of its extent, and the variety of ways in which the need was expressed. At times there was a great deal of agreement between the three groups, yet in some cases needs that were identified by one group were not acknowledged by another. Differences and similarities both between groups and also within each group will also be addressed.

### **5.3.1. Need for Information**

The category “Need for Information” encompassed not only data about young peoples’ description of their needs for sexual health information, but also any other information that they thought might be useful, or even crucial, in their everyday lives. In the case of peer educators, their opinions about their needs for further information *as young people* was included in this category, as was their opinion about their need for information *as peer educators*. The professionals’ opinions about the sexual health information needs of young people fell into this category, as did their assessment of their own needs as professionals in terms of sexual health information and training.

#### **5.3.1.1. Formal sources of sexual health information**

The need for sexual health information and education to be widely available to all young people was unanimously supported by all three groups. Every young person I interviewed believed that sexuality and relationship education (SRE) was important, and most were eager to discuss ways it might be improved. This was especially evident among young

people who had been exposed to formal SRE (in one way or another) and had a point of reference to build on.

Among the sample of young people, 19 reported that they had received at least some SRE from an institution, whether a school or the Pupil Referral Unit. While the information proved somewhat useful, most of the young people described these lessons as inadequate for a variety of reasons: they were given too soon or too late; the information was too graphic while not being relevant enough to the context of their lives; they weren't taught where to go for more help; the teachers or the students were embarrassed or uninterested.

Most received few sessions, less than one a year, which might be due to the school policy of not providing sexual health information at the primary school level—bearing in mind that most of my sample had a history of drop out after primary school. And those that remained in school had a history of truancy, so it is possible that they missed the few sessions that were provided. YP09, a 15-year-old who dropped out of school because of bullying, laughed when she said: “. . . they probably did sex education but I probably weren't there” (YP09, F, 15, mixed race). She did not seem to think she had missed anything.

Because most young people do complete primary school, including those who eventually might become NEET, those would seem to be ideal years to provide SRE in terms of reaching the largest number of students—that is, before they drop out or become “hard to reach”. Many young people agreed, particularly those who were native to the UK or had lived here for some time:

“It’d have been easier if it would have been earlier like to have it when we were in year 5 or year 4 or something. It would have been better . . . . They probably thought we were too young didn’t expect us having sex and all that.” (YP15, white-British 14-year-old female)

Even among those who thought primary school was too young, there was also the sense that waiting until the latter half of secondary school was too late, as many of them had already become sexually active by then. Among the sample of peer educators, the experience of receiving sexual health information in a school setting was more or less the same as young people in the category of “hard to reach”.

Young people in BETS seemed to have had a somewhat better experience with the sexual health education provided there, keeping in mind that the sample I recruited was from one Pupil Referral Unit and the experience might be different for those attending a different PRU. Overall they seemed to enjoy the sessions and found them useful and relevant. This might be due to the fact that young people who attend PRU in general are considered to be at a higher risk, therefore their SRE sessions might cover more preventative material than mainstream schools. It seemed that because SRE was taught as a life skill young people took it in and it was interesting for them:

“. . . they gave us this baby that if we didn’t hold it right it cried . . . it was funny but at the same time it shows you how difficult a baby can be . . . it is good . . . they tell us how to money planning . . . it is practical here you can use the lessons in your everyday life.” (YP12, 14-year-old male)

The fact that they did not separate SRE from other necessary everyday skills also positively affected the young people’s perception of their need for this information.

### **5.3.1.2. Informal sources of sexual health information**

Most of the young people I interviewed did not attend school regularly, therefore SRE sources outside school could have an even more important role in their lives. They tended to draw a lot on their own life experiences, or the experiences of people close to them, rather than more formal types of SRE that might provide them with abstract information but ultimately did not answer their questions. Not surprisingly, they expressed a great variety of preferences for receiving sexual health information, though patterns did emerge among young people from similar ethnic, cultural, or religious backgrounds.

Young women from African or Caribbean backgrounds in this research were more likely to report that their mothers or aunts told them about menstruation and birth control:

“Although I said I don’t feel that I got enough information from my school, that’s not the only source because my mum educated me from a young age . . . You do feel some level of embarrassment cause you’re young but she was the best person to give me the information cause I am very close to her . . . she is close to all us [siblings] . . .”. (YP10, 19-year-old black-British Caribbean female)

When I asked YP10 if there was a time she approached her mother she replied: “No, it was more like a case of, she answered it before. She’d save me the embarrassment cause she’d cover everything I’d needed to ask her”. Not only did her mother provide her with information, she also had the sensitivity and awareness to do so without being asked.

Among the group of Peer Educators were three males and two females of Caribbean or African descent that also received sexual health education at home from their mothers, one of whom had the good fortune of having a mother who is an outreach worker. Another believed that:

“... parents know you and they want good things for you so it's better to get it from your parents than strangers. So when your parents tell you probably listen. Even sometimes you think you are not listening but even that you know when they sit down and say ya here is the talk, you're gonna listen anyway and you're going to respect the fact that they are talking to you.” (PE06, F, 17, black-African Nigerian)

The cultural emphasis on open lines of communication between adults and children was also apparent in the interviews with professionals. “White” professionals tended to view SRE as the domain of professionals like teachers, youth workers, key workers and health care providers. Those from African or Caribbean cultures, on the other hand, emphasised the need to reach out more to parents, and they make efforts to include parents when they can. This is not meant to be a solid categorisation of different racial or ethnic groups and their attitudes towards this particular issue; however, it seems that coming from cultures which emphasise individualism (such as Western European cultures) versus those that are more collective (Airhihenbuwa, 1995, p29) and community based (such as African or Asian culture) could play a role in allocating responsibility for the delivery of information to young people (also see Nasserzadeh, 2009a). Prof12, a 29-year-old black-British outreach nurse who had previously worked as a teen pregnancy advisor, relayed that she was sometimes challenged in trying to “make a path” between the parents and the young people. She said that in her own culture parents and other adult family members like aunts and uncles are important providers of sexual health information, yet she finds that more and more this tradition is not followed:

“... I think the way forward is to educate parents, talk to parents about these situations and tell them to accept that young people at some point will be sexualized and will be having sex and it's probably better to accept that rather than just to ignore it so just pretend that's just never gonna happen.” (Prof 12).

Prof03, a 25-year-old black-African youth worker, reported that homelessness presents a huge risk for unsafe sexual activity, so he makes efforts to mediate conflict between young women and their parents so that the young women might be more comfortable staying at home. And Prof10, a black-British manager of a leaving care team, explained that the young women who tend to get pregnant are those who “. . . didn’t really come from family backgrounds where there’s a lot of parental I wouldn’t say control but parental oversight of what the young person was doing, you know?”

Being sexually active seems to be more acceptable in African and Caribbean communities, which might make it easier for young people to approach an adult in order to acquire information. At the same time, there seems to be a fine line between what is accepted and what is expected, and several professionals mentioned that the pressure on young black men to be sexual and masculine is immense. The need to appear sexually confident and knowledgeable is likely a part of this, and might go some way towards preventing these young men from seeking the information they need. They think they should already know everything.

Parents did not appear to be a sought-after source of information among young people from a white British or Irish background in this research, who tended to use words like ‘scared’, ‘embarrassed’ ‘uncomfortable’ or ‘fear’ when describing how they would have felt if they were to talk to their parents about their concerns or ask them questions regarding their sexuality. One 14-year-old white-Irish Christian female shared that: “Yeah, me and my mum are close,” yet when I asked her if her mother knew she had had sex she replied: “No, she would kill me . . . . Yeah, I can ask her questions about it but she don’t know that I’ve

had it, otherwise I'd get in serious trouble" (YP12). She explained that she practiced with a friend before she spoke to her mother:

"I didn't know how to do it and I was scared to ask my mum, then [my friend] will be like, 'Practice on me, ask me the question and I'll tell you what she knows' and then I'll ask my mum and then I'll get more information and then I won't be so scared when I ask . . .". (YP12)

She believes her mother can give her more information but only if she can overcome the initial fear to approach her. A similar reluctance was present for most of the young white British young people, and could imply that they do not have the type of connection with their parents that would make initiating such a conversation likely. Instead, they seemed to prefer receiving sexual health information from a more formal setting like a clinic or a school.

Young people from Muslim backgrounds also exhibited a reluctance to talk to their parents about their sexual health concerns, though, for them, this had less to do with the closeness they might have felt with their parents and more to do with the concept of respect. Girls particularly mentioned that they would prefer to avoid this because they did not want to be seen as sexually 'curious', or for fear of *disrespecting* their mothers:

"I would not ask my mum because I don't want to breach the respect between a mother and daughter... also I am her little girl...maybe she wants to talk about it but I won't feel comfortable". (YP08, F, 17, Iranian, Muslim)

"In my family we have a lot of respect, we put everything down to respect basically, it's not right for your child to come and speak to you about sex" (YP07, F, 16, Iranian, Muslim).

Young Muslim males, particularly those who were born elsewhere and emigrated, seemed to prefer getting their information from a GP or from the internet, and several



cited discomfort as the main reason for not going to a clinic or for not wanting SRE in school or in a group setting: “That’s the best way to search, like if you’re gonna have a problem about sex you’ll be sometime ashamed to aks someone else so you might explore and search on the internet” (YP03, M, 19, Bangladeshi). He, and others, also expressed a preference for not receiving leaflets on the street: “. . . because when your mum is there and your dad is there and you’re gone passing that’s embarrassing”. (YP03).

Young people from a Muslim background all mentioned that they would prefer to have an ‘adult specialist’ *tell them what to do* instead of a peer or someone with no speciality discussing their *options* with them. This might be because of the existence of a hierarchical concept within Muslim communities and the fact that there are very clear-cut rules to follow in one’s everyday chores. Also in Islam there is a great emphasis on the respect that should be paid towards one’s parents and elderly, which might explain why Muslim young people mentioned the concept of respect more frequently than non-Muslims in this research.

This idea of respectfulness also arose for young Muslims when it came to the method of delivery of sexual health information. Though interested in receiving the information, some were uncomfortable with either the content of what was taught or the method of teaching:

“It’s kind of disturbing to see things like that when you’re 11 years old . . . the woman was having a baby . . . and when you’re 11, you just get freaked out at seeing things like that” (YP07, F, 16, Iranian, Muslim).

It is important to point out here that she did not take exception to the fact of SRE because of her religious or cultural beliefs, but only because of the method of delivery. In fact she

believed that the SRE she received was inadequate because there wasn't enough relevant information.

Even those who questioned whether SRE might in fact encourage promiscuity nonetheless accepted that ignorance of the facts might be dangerous. Two young men in particular had strong feelings about the provision of SRE to young people; both also came from cultures where it is expected that one will wait until marriage to have sex:

“... if you want to give them condom they want to do sex, [the] more you give [the] more they want to do, but if you [do] not give them maybe they would do sex without condom and maybe they would get some disease and it's quite hard to explain...I think this [is] bad, but if you [do] not give them [condoms] they will do without condoms and it is bad in the end [either way]. I don't know (laughter) yeah...” (YP23, M, 16, black Angolan, Christian).

Another young man, who emigrated from Turkey as a boy then later left home because of undisclosed disagreements with his parents, expressed some very strong opinions when asked how he felt about the sexual behaviour of young people in Britain:

“Oh my God don't ask me those, oh my god they are so rude . . . I had a couple of girls and boys you know just running riot and they were doing stuff that I would have been ashamed of . . . after a day of sex education there's too much information than we need, because youngsters do attempt to try . . . you should give them that information [but] they should soften it up, especially for young kids . . . try and be a bit more, not less open but a bit more covered I would say.” (YP20, M, 20, Turkish, Muslim).

Both also explained that in their countries of origin sexual education is handled very differently:

“Where I come from you only know what you got to do on the first night of your marriage, which is dad [for the man]; this was the eve of your wedding, the girl's mum whispers to her. So actually that is stupid, I'm really against that, I mean you should know what you're doing but you

know there should be honour, not too much information but there should be enough information out there.” (YP20)

It is important again to recognise that these young men ultimately agreed that the information is important; they simply did not agree with how it is delivered.

In fact, all the young people I interviewed felt that SRE was important, regardless of their ethnic, religious, or cultural backgrounds. Of course, because my sample was to some extent a self-selective group— anyone who was tortuously uncomfortable talking about sex would not have volunteered to participate in the interview—it is possible that there are young people who would prefer not to receive this information in any form, at any time. However among my sample there were 8 young people who considered themselves fairly devout (on a 5 point Likert scale in the demographic form, two marked **5** and six marked **4**), yet even these expressed a belief that sexual health information is necessary.

### **5.3.1.3. Content**

Regardless of the sometimes significant differences in how young people would prefer to receive the information, the content of the information was relatively consistent for all young people, regardless of their cultural background, level of religiosity, or even level of sexual experience. They all wanted detailed information on how to protect themselves from STIs and unwanted pregnancy, and contact information for additional services should they find themselves in need of help. In their own words, they want to know “Like, everything”:

“How to put on condom properly, what you can catch, condom can split and you can use creams and different other things that you don’t get pregnant. Just all that sorts of stuff . . . They should’ve just told us . . . It

was all right but it wasn't anything practical . . . cause some adults think kids in year 4 and 5 are too young, but they need to know . . . it wasn't the information we needed like . . . they should just talk to you about *everything*, show you and demonstration and like Depo Provera, condoms, etc." (YP15, F, 15, white-British)

"Like *everything* you need. *Everything*. Like might be disease you might caught." (YP02, M, 17, black-African Somalian).

"I think they could give us a bit more. About *everything* really, em, I don't know just like *everything* just cover sexual stuff like what can cause pregnancy, disease . . . they need to tell us a bit more about it." (YP14, F, white-British, Christian)

The only differences were between genders—young men tended to stress STI prevention over contraception, whereas young women were interested in both. In other words, young men seemed to believe that the burden for contraception fell on the female, and felt no need to seek out the information for themselves.

Along with the information young people *did* want to hear about, there was also some talk of things that they specifically *did not* want to hear—mainly having to do with the importance of having a relationship of some sort with one's sexual partners and being able to communicate openly with him or her. One young woman thought the SRE she received in school was good because the teacher:

" . . . just kept her opinion to herself and she just told us the truth that we can think about it as well". (YP18, F, 17, black-Caribbean)

Another mentioned that:

"They give good information but like in the leaflet they mentioned about sex but it said like if you love the person then that's it you will have sex. But it's not like that no one is waiting for some one they love if they want to do it they just do it ain't? But they keep bringing it up 'if you're in a loving relationship' then it's not realistic, back in their day maybe it was but now a days it's not like that they shouldn't really put that in a lot of

people are gonna think ‘yaya whatever’. That is good information if they say what it is, how you can get it and where to go for help.” (YP06, F, 17, white-British, no religion).

However, the same young woman also expressed an interest in seeing a documentary about the dangers of unprotected sex. When I asked her to clarify she described a scenario in which a young girl contracts an STI after being pressured into unprotected sex by a partner:

“Like a young girl and there is a boy and he just wants to get sex from her but she wants a proper relationship they’re like about to do it and he is lying down but doesn’t have the condom and trying to pressurizing her to it. And he is telling, like, ‘Oh but if you really like me what’s the problem?’ . . . and then at the end she can do it and then end up catching something and she got it from him . . .” (YP06, F, 17, white-British, no religion)

This introduces a few remarkable points with regard to the young people’s interviews generally. First, that many of their expressed needs for information seemed inconsistent with the stories they told about themselves. Several young women like YP06 told stories of being pressured to have sex before they were ready, yet none of them asked for or was interested in information about communication skills in relationships. Second, the story related above brings up an important question regarding who is best suited to determine young people’s sexual health information needs—young people themselves, or adults such as parents, educators, and sexual health professionals?

There was a general feeling among the adult professionals interviewed that some young people simply do not know what they do not know. They might think they are well informed, but might instead be misinformed, particularly if they have not received any formal SRE. Perhaps this is why professionals, and to a lesser degree peer educators,

appear to have a somewhat different idea of what kinds of sexual health information young people need.

Among professionals, there was a recurrence of phrases that rarely or never appeared in the young people's interviews, such as, "communication"; "self-esteem"; "abuse"; "exploitation"; "relationships education"; "negotiation"; "coercion"; and "consent". The three main areas that emerged from these interviews (and that were either somewhat or entirely lacking in the interviews with young people) were relationships skills like communication and negotiation, self-esteem, and issues of coercion and consent.

Most of the professionals considered that communication skills generally, and condom negotiation skills in particular, were important components of sexual health education:

"... the key ones are relationships, so what do young people want from relationships . . . and also being able to ask questions in relationships and being able to talk with their partner and I think that's a key way of keeping themselves safe." (Prof04, M, white-British manager of outreach service)

"I think that young people who don't have life experience, who are not emotionally that developed, unfortunately don't recognize the importance of the relationships that they're having . . . so sex becomes like a cup of tea, you know what I mean? . . . It should have a bit more value than that." (Prof 11, F, black-British manager of a leaving care team)

Though peer educators did not generally stress relationship education, a few, notably female, did identify that as a need for young people:

"... not every young person know what it is to be in a relationship so relationship advice will be helpful cause no one really focuses on that." (PE11, F, 17, Jamaican)

“... maybe more the relationships than STI and stuff, because obviously if I could communicate with the person that I am gonna have sex with, if I could talk to the person openly ... then I think I might do it with this person. I think relationship, then STI.” (PE07, F, 17, Caribbean-black-British)

Yet how is one to reconcile the stated needs of young people, which do not include relationships education, with the professional's perceptions of what young people need? There was a real sense of a generational divide; young people want someone who understands the realities of their life contexts and will not try to dissuade them from having the kinds of relationships they want to have.

This preference for not receiving relationship information seems to be the case among the young people I interviewed, but is perhaps not true for young people more generally, especially those who remain in school. Prof14, a curriculum developer for SRE sessions in schools, emphasised relationship education in the sessions he designed. When I asked him if he believed this was in keeping with what the young people want to hear, he answered:

“When we do needs assessment or when we are asking young people, these are the main areas that come up most. They want to know what the risks are, and they want the facts ... but what they also say is that there is too much facts and not enough discussions of relationships, of attitudes, of feelings.” (Prof14, M, white-British curriculum developer)

There is a long standing literature that suggest young people who stay in school and have a more *normative* adolescence are likely to have a different view of sexual relationships than those who drop out (e.g. Ensminger, 1987, p45; Hargreaves, *et al.*, 2008). The observations of Prof14 seem to support that.

Another issue that was raised by professionals yet not mentioned by young people had to do with self-esteem:

“[We need to] make connections between their mental health and their bodies.” (Prof01, F, 23, black-African Somalian outreach worker).

“Negotiation doesn’t always come up but I think it’s quite important to trying to help young people to negotiate and a lot of that is down to self-esteem . . . I think if you could teach a child to love themselves maybe they wouldn’t take the risks they do.” (Prof12, 29, black-British outreach nurse)

“. . . unless they feel at a place where they actually want for . . . they value themselves enough to actually look after themselves, they won’t. So they can have the information, but if they feel that they’re worth nothing, then there’s nothing to encourage them to have safe sex . . .”(Prof04)

Though low self-esteem was identified as a barrier to safe sex practices, most professionals also recognised that their abilities to impact young people in this regard were somewhat limited as self-esteem is not something that can be taught in a single SRE session, or even in several sessions. Yet this observation does shed some light on the kinds of risks young people take and some of the reasons behind those risks.

Though peer educators did not stress self-esteem by name, it came up in the interviews in an indirect way when discussing barriers to seeking information or treatment:

“. . . you have to cope with certain things. If you got an STI you might be ashamed of it, or feel dirty that you have got it so how you would cope with that mentally, it’s not just a physical thing to go and sort this out” (PE07, F, 17, Caribbean-black-British).

Young people also did not mention self-esteem *per se*, though the issue did come up throughout the interviews in subtle or indirect ways. Many young people expressed a certain degree of embarrassment in seeking out sexual health information or services,



such as YP12, a 14-year-old white-Irish female who asked a friend's father to get her a pregnancy test from the chemist. When I asked her why she did not get it for herself, she explained: "Because they'll look at me like some sort of little whore or something . . .".

High self-esteem is known to be one of the core competencies that help a young person engage in safer sexual behaviour, including the use of contraceptives (Charles and Blum, 2008), and there appears to be a link between having a positive self-image and taking care of one's self. This positive correlation seems to apply when self esteem refers to the concept of self worth, which is seen as an important component of a young person's ability to negotiate safer sex or seek information (Rostosky, et al. 2008).

The subject of sexual coercion or exploitation was likewise not identified by young people as an information need, though it did come up in two of the interviews. YP09 reported dropping out of school because she was sexually attacked, and YP05 disclosed that she had been sexually abused by her step-father. However this was a subject that most of the professionals raised, particularly those who work with young people at risk for sexual exploitation:

"... if a 14 or 13-year-old comes to me and they . . . present with an STI I am going to worry, you know, I am going to think an adult had sex with this person. It needs to be investigated." (Prof03, M, black-African youth services coordinator)

"[We] can't just put a wall around young people, you know we live in a society and there has always been adults and there always will be, I think, unfortunately, adults that abuse young people, so it's about giving children the skills to protect themselves as well as trying to protect them." (Prof04, M, white-British youth services manager)

The issue of abuse also came up for several peer educators, who tended to stress abusive relationships as opposed to prostitution or other, more explicit forms of exploitation.

There are several reasons why young people might not have identified a need for information regarding sexual exploitation or abuse. First and foremost, I did not ask them about it. Perhaps if I had they would have been more forthcoming however as I was a stranger they might not have wanted to discuss this with me. The young people I interviewed generally insisted that the information they needed was of a more practical nature—STI prevention and contraception—and did not stress relationships in general, even potentially abusive ones, at all. Even the young women who felt pressured into sex before they were ready seemed not to think of this as an area in which they needed help or information. Though professionals saw young people as being especially vulnerable to these risks, the young people did not seem to recognize themselves as vulnerable—or, if they did, were unwilling to admit to it in the interview setting.

Again, this brings up the question of how far we, as adults, are responsible for providing the information we think is necessary, and how much we should take into account the needs of young people as expressed by themselves. This is particularly significant for socially excluded young people who often do not feel “heard” by the society in general:

“ . . . professionals, they just think what they think, they don’t want to take into account what other people think or the person that they’re treating thinks, cause that’s happened to me a couple of times . . . You go from where you tell them a bit about your experience and they’re like, ‘No, that’s not right. This is right’. It has to be both ways, it can’t just be what the opposite thinks, it has to be my opinion and my views of the situation as well . . . [They give you] what they think is relevant, not what you think is relevant” . (YP07, F, 16, Iranian, Muslim)

Many adults feel strongly that a monogamous, committed relationship where communication is ongoing is the best defence against the risks of being sexually active, yet if we emphasize this we may well be alienating the very people we are trying to help.

#### **5.3.1.4. Lack of perceived need for information**

Despite the inadequacies of SRE sessions provided in formal educational settings many of the young people I interviewed felt that, eventually, they perceived their level of sexual health information as satisfactory. They learned it from friends, or from their parents; from leaflets they received on the street or at a sexual health clinic; from magazines or from the Internet; from social workers, key workers, or teachers. When I asked questions regarding their perceived need for further information—such as: “If I were a sexual health professional, would there be any questions you would want to ask me?”—12 replied that they had all the information they needed, 4 either did not know what to ask or could not think of anything, and 6 expressed a general need for more information about STIs and contraception, though none had a specific question for which he or she was seeking an answer. One 19-year-old Bangladeshi male explained: “I don’t really want to know nothing. I already know about stuff that I know so there is no other stuff that I need to know” (YP03). This type of response was fairly typical.

Young people’s overall confidence regarding their perceived need for sexual health information raises several issues. To begin, it seems possible that those who did need or want additional information simply did not want it from me. Embarrassment is a significant factor for most young people, and I was a stranger to them.

It is also possible that the young people I interviewed simply “don’t know what they don’t know”—that is, they do not have enough of a knowledge base from which to ask informed questions. One peer educator, an 18-year-old white-British female, explained that she would prefer to be given sexual health information in presentation form: “. . . because I wouldn’t know what questions to ask you” (PE02). This could be even more relevant for those who have received no formal SRE sessions whatsoever.

Another peer educator told me: “I think they’re lying that they have great knowledge; I think they have a little bit of knowledge and they think ‘Ah, yes, I know everything now’ ” (PE08, M, 15, black-African-British). It certainly seems possible that it is overconfidence, rather than ignorance, which causes young people to underestimate their needs for sexual health information.

One young woman, a 16-year-old Iranian Muslim, reported that she felt she had all the information she needed to begin sexual activity at 14: “. . . because teenagers talk about it a lot and discuss it, so everyone puts in a bit and then you learn a lot, so I think yeah I did have enough experience” (YP07). A quick look at this young person’s choice of words suggests that she has replaced the concept of having enough *knowledge* with having enough *experience*. One wonders whether young people use these concepts interchangeably, which could go some way toward explaining their confidence regarding sexual health information. This young person thinks she does not have a need for sexual health information because she has had sexual experiences, therefore she thinks she must have had enough knowledge to engage in a sexual activity. However, given that her information came largely from her peers, she might not have necessary or accurate information to protect herself against unintended consequences.

Several of the young people interviewed, peer educators included, felt confident about their level of sexual health knowledge yet said things during the interview that indicated they were misinformed. They believed they had the knowledge because they had received at least some form of SRE and had heard the words (“use condoms to prevent STIs”; “use birth control to prevent pregnancy”) but this did not necessarily mean that they really understood what was discussed. For example, one peer educator recounted his understanding of HIV and AIDS as follows:

“Another thing they don’t know is that HIV is not really a sexually transmitted disease or infection, everybody has HIV, cause I’ve learnt this recently, it [HIV] breaks down your immune system and once your immune system is broken down something like pneumonia you’ll catch and that could kill you. So basically everyone’s got HIV but depends on how much sex you have and [how much] HIV you have that will break down your immune system that will be transmitted to the next person which will break down their immune system and something that’s sexually related can break and kill them.” (PE08, M, 16, black-African-British)

Hearing the above statements from a peer educator was a bit alarming, especially because this young person mentioned that he was confident regarding the sexual health knowledge he had. It also indicates that at least some of the peer educators may also be overconfident with regard to their understanding of sexual health issues.

Peer educators, like their counterparts among the group of NEET young people, generally did not express a need for more sexual health information *for themselves*, though some did express a need for more information *as peer educators*:

“I might need more information on actual STDs and STIs cause I have a slight information . . . I need to be given information on individual [diseases] like gonorrhoea, what their side effects are, what happens or about discharges and stuff. I need to understand more cause I am gonna get ask on them cause delivering the information, I am gonna have forgotten.” (PE05, M, 17, black-Caribbean-British)

In other words, they felt they needed information to help them in their work, but not for themselves personally.

This was typical of peer educators generally—though they came from similar socioeconomic backgrounds as their clients, they nonetheless tended to view themselves as being somehow apart from the peers they were educating, and many assumed a kind of authority:

“... we want to provide options for young people to enjoy themselves and just show us their values basically and we have to stay by our values. Our values have to be positive to give a positive affect to these young youth today, and that’s what I am about that that’s what I believe I was created for—to become a youth worker and help young youth get out of that circle they are in at that moment and bring them to a more positive vibe circle. And that’s what I wanna do.” (PE02, F, 18, black-British)

This intra-group social mobility and the process of social distancing for peer educators have also been reported elsewhere (Population Council Consultancy report, The Horizon Project, April 18-21, 1999, p 11).

In truth, many of the peer educators did come from somewhat different backgrounds than the “hard to reach” young people. For example, none of them lived alone or with friends, and all but one lived in a household with both parents. Perhaps because of this, they did not tend to face the same kinds of challenges with daily living as those in the “hard to reach” group.

#### **5.3.1.5. Competing needs**

The daily challenges faced by young people in the “hard to reach” group may be at least partly responsible for why they do not seem to have sexual health at the top of their agendas. Considering their competing needs—for housing, for help, for money—it seems

likely that this is not an issue that feels particularly urgent to them. YP04, an 18-year-old male from Somalia who is seeking asylum in the UK, would not allow me to tape the interview because he was afraid it might have a negative effect on his status. When I asked him if he had any questions about sexual health, he replied: “Don’t need any information; have all the information; don’t have any questions”.

Another young man (YP21), had his first child at 15 and at the time of the interview he was 19 and was expecting his second. He was living in Haringey but felt it was not a nice neighbourhood and did not want to raise his children there. He had been “kicked out” of school at 13 and had never returned. Regarding any perceived need for sexual health information, he said: “No, I know everything . . . yeah, I’m smart, I learned things” (YP21, M, 19, black-British).

And YP12 is a 14-year-old white Irish female who lives with her mother and her little brother. Because her mother has epilepsy, she takes care of them both, and says: “It’s hard. Really hard. Very stressful, you know?”. At the time of the interview she did not think she needed any additional sexual health information, and explained, “I’ve got all the answers now. . . Yeah, all the answers I was looking for I’ve got so it doesn’t matter now”.

Every young person I interviewed had his or her own story, each of which included circumstances or situations that placed other demands on his or her time and attention. For some, finding someone to shape a relationship with (to help them with not feeling lonely) might be their first priority; negotiating safer sex might come in second, or even not at all for fear of losing the relationship.

The complexity of their lives appears to have a direct impact on their perceptions of need regarding sexual health information; it is not difficult to understand that it might not be at the forefront of their minds. Instead they tended to ask for information that was more relevant to their immediate needs. For example, YP14, a 15-year-old white British female, was thinking about getting pregnant and wanted to hear about the experience directly from *teenage* mothers. She also wanted to know about housing available to *teenage* parents. And PE06, a 17-year-old black African Nigerian female, felt that in addition to sexual health information, people need to know their rights as citizens, particularly young black men:

“... police stopped one of my friends and then he asked why they are stopping him and they said because a lot of young black boys are committing crime so we are stopping them . . . So a lot of people should know about their rights because as well as sexual health like they need to know about their rights as a citizen.” (PE06).

Although this is not directly linked to young people’s need for sexual health information, it does refer to the ways sexual health might (or might not) fit into their everyday life and priorities.

#### **5.3.1.6. Other factors that impact on the perception of need for information**

It also seems likely that young people’s confidence about the adequacy of their sexual health knowledge has at least something to do with their age—thinking they know it all is typical of many teenagers, not simply those who are “hard to reach” (e.g. Raffaelli and Crockett, 2003). Also, the older they are, the more likely they feel confident about the knowledge they have (Ybarra, *et al.*, 2008). Of course, those who are NEET, or who are



living on their own (with or without friends), might be at a higher risk of early and unsafe sexual activity (Tripp and Viner, 2005; Social Exclusion Unit, 1999b), so their overconfidence could be more likely to produce negative health consequences.

International data suggest that the sense of over confidence can follow with a sense of invulnerability that could have an enormous impact on a young person's sexual health behaviours, hence increasing the awareness of susceptibility could encourage young people to seek out the information they need to protect themselves. (UNICEF Opinion Poll 2001).

The professionals overall seem to agree with this line of thinking:

“If I came to a class and said, ‘Good Morning class, my name is [John] and I’m here to talk about sexually transmitted infections. Gonorrhoea, It’s a bad disease, it will kill you’. Yeah, you know, they will think, ‘Let me come to that and then it will kill me’. Young people think of later, they never think of now. I don’t know if you know that? If you say to a young person that there is a cure you’ve solved their problems . . . . But if you come with pictures, diagrams, and in your method of delivery you use factual images, young people will respond . . . . it reminds them that they could be one of those [statistics] and that changes a lot of young people.” (Prof03, M, black-African youth worker)

Several young people also cited drug and alcohol use as an impediment to safer sexual practices, and one young woman reported that she feared she might be pregnant because she had failed to use a condom:

“Oh that was because I was drunk, at a party we were drunk, me and my boyfriend were drunk and like we didn't have any plus you know when you're drunk you can't bothered sort of thing cause like so he never put on the condom, but I was all right in the end so that's all good . . .” (YP12, F, 14, white-Irish)

It seems significant that she believed everything was “all good” in the end as she was not pregnant, but the fact that her drinking led her to make a poor decision was not something she focused on. While listening to young people, it seemed that alcohol consumption could be used to justify (or as an excuse for) certain sexual behaviours. This has also been reported elsewhere (Weinhardt, *et al.*, 2008; Bailey, *et al.*, 1998). Though the professionals mentioned a need to provide drug and alcohol education, either separately or conjointly with sexual health education, the young people seemed less concerned with this issue. Though a few believed it might be useful, and even made the link to unsafe sexual practices, they did not bring it up on their own initiative. Peer educators had a somewhat stronger stance, but even they generally left it out of the conversation unless I mentioned it specifically, at which point they would offer some agreement. Even those young persons who seemed at risk for drug and alcohol dependency did not express interest in changing this behaviour or learning more about it. This led me to believe that perhaps they view these types of risk in much the same way they view the risks of negative sexual health consequences—they have other things on their minds and they do not think they’re susceptible to the dangers involved. Even if they realize the possibility of danger they seem indifferent.

Several young people also mentioned being carried away in the moment as a reason for not using contraception. They had perhaps not planned to have sex and so were inadequately prepared.

Young people’s confidence that they had all the sexual health information they needed goes some way towards challenging the idea that a lack of information is the problem. If,

for a moment, we accept that they do indeed have all the knowledge they need in order to protect themselves, we are left with the question of why they are engaging in risk-taking behaviour despite knowing better. This is a much harder problem to explore. If, as some professionals suggested, it comes down to issues of self-worth or self-esteem, the solution from a public health perspective is not so clear-cut.

From an outcome-oriented perspective, one expects a person with good knowledge to end up with a certain outcome—namely, STI free. So the question arises: do young people lack sufficient knowledge to protect themselves, or is the knowledge itself not sufficient to inform their behaviour? For example, YP08 is an 18-year-old Iranian female who was raised in Sweden where she received what she believed to be very good sexual health education. Yet she was interviewed in a sexual health clinic where she was seeking treatment for an STI. Though most of the young people I interviewed insisted that they themselves practised safe sex, they all knew others who did not. The main reason they cited was that most people “can’t be bothered”, a phrase which came up repeatedly regarding this issue. There is a vast body of research on the failure of knowledge alone to shape ‘*normative*’ behaviour (e.g. Dinkelman,*et al.*,2006; Airhihenbuwa and Obregon, 2000).

If one takes a right-based approach, it is easy to see that the burden for providing sexual health information falls on the Government—the way that young people use the information, or do not use it, is up to them. Young people and professionals agree that this information should be as complete as possible, and ideally should include both the physiology of reproduction and accurate information on contraception and sexually transmitted infections. Most professionals likewise encourage at least some level of

relationship education, particularly interpersonal communication and condom negotiation skills, and they would like to be able to provide additional information on the risks of sexual exploitation and sexual abuse. Professionals were also aware that encouraging positive self-esteem might have an impact on the way the information is used by young people.

When it comes to “hard to reach” young people, however, the issue of providing sufficient information becomes complicated. As many of them do not receive sufficient SRE in school, other venues for provision must be developed. Young people’s overconfidence regarding their sexual health knowledge, in conjunction with a perceived invulnerability to the risks of sexual activity, complicates matters further. Many do not feel a pressing need for more information, particularly given the fact that their lives often include more urgent demands on their attention and resources.

From an outcomes-oriented perspective it could be argued that the information deficit model is not applicable here as providing the information alone is not going to save these young people’s lives, or change their attitudes or behaviour, unless we can ensure that they have the ability to use the information to inform their actions (Airhihenbuwa, Obregon, 2000). In order for this to happen, the simple statement is “their whole lives might have to change”! Here it becomes an issue of needing help to get their lives to matter, first from their own perspective and later from the rest of the society’s perspective. Only then will they begin to concern themselves with their own sexual health.

### **5.3.2. Need for Help**

Expressed needs for help from each group were included under the umbrella category *Need for Help*, whether they were expressed by young people, peer educators or professionals. Thus if young people mentioned that they need help with their financial management or housing, or peer educators mentioned they needed help with furthering their education, or professionals mentioned they needed help with specific training or professional support, all would be included in the category *Need for Help*. Also included in this category were areas in which young people had needs for help that were not specifically expressed but were implied in the interviews.

#### **5.3.2.1. Young people seek out help rather than information**

Young people seem more likely to seek out sexual health services when they need help, rather than information—that is, when they have a specific problem or concern which is sufficiently troublesome to eclipse their other needs at that moment. The need for information is secondary, as a part of the whole package to resolve their situation.

Several professionals pointed out that some young people might need help just getting to the clinic in the first place, even when they do have a specific problem. Sometimes they are referred then do not show up for the appointment. With this in mind, several of the professionals stressed the importance of providing sexual health information in clinics or other healthcare settings, such as doctor's offices, where young people come seeking treatment and are, in a sense, captive in such settings. What's more, because they have come for help they are potentially more aware of their susceptibility to negative sexual health consequences than they might be in their everyday lives, as negative consequences are most likely responsible for their visit in the first place. As we

saw above, offering them information during times when their sexual health is not foremost in their minds is more difficult, as many of them believe they already know what they need to know and they have no further needs for information.

Several professionals also mentioned that with “hard to reach” young people this is especially important because their visit to the doctor or clinic might just be the only opportunity one has to provide information. Many of them do not come back a second time, even for a follow-up visit after receiving treatment.

Prof06, a school nurse for 18 years who had previously held a position as a practise nurse, made the point that general practitioners could be an excellent source for providing sexual health information to “hard to reach” young people. Though many do not have access to a school nurse, and though they might not choose to attend a sexual health clinic, most of them do visit a GP at one time or another for a variety of reasons. She makes sure to tell “. . . every child that I see or meet, anyone, any parent who has got relatives that are not accessing service, to go to the GP”.

#### **5.3.2.2. Professionals’ needs for help**

One of the areas for help most often cited by professionals was the need to train *other* professionals in providing sexual health education, so that it might be done opportunistically rather than formally (Holland, 2007 p122). As most “hard to reach” young people are not in school, they are not likely to have received sufficient formal SRE sessions. Thus they need to be given information whenever and wherever possible. Prof10, a black-British woman in her 40s who manages a leaving care team, thinks that providing this kind of information ideally would be “. . . a joint effort by all the people that know a young person”.

She went on to explain that young people are more likely to ask questions of someone with whom they feel comfortable, yet this is idiosyncratic and depends on individual human relationships. She, and others, agreed that all adults with whom a young person is likely to come into contact, including teachers, social workers, key workers, or those who provide other services, should be comfortable providing this kind of information. If a young person seeks out help for any situation, and if they have some kind of rapport with the professional who is helping them, it could develop into an opportunity for a discussion of sexual health issues:

“[W]e should all have a bit of knowledge about all sorts of areas that impact upon young people because they’re not necessarily going to wait three days until they see a social worker to ask, you know, ‘Where can I go and get the emergency pill?’ You know if they happen to be in front of the educational training and employment worker and that person has the knowledge and they have a rapport with that person, you know, why shouldn’t they be able to ask that person rather than wait to see their social worker? . . . it doesn’t matter where it comes from as long as it gets there.” (Prof10)

Prof04, who runs a youth programme, and Prof03, a youth services coordinator, also mentioned the need for this type of training:

“Mind you, every young person knows if I’m stuck I go to the youth service because that’s what it’s there for. So once these guys are fully trained they will not only target young people on a level ‘I have a housing problem’ but also on the level of ‘I can help you with sexual health and here it is’.” (Prof03, M, 25, black-African, youth services coordinator)

This type of opportunistic SRE is seen as having the added advantage of being one on one, which allows the providers to tailor the material to fit the clients, taking into consideration ethnic or religious backgrounds, levels of previous knowledge, and other life circumstances which might affect their needs. It also goes some way toward

neutralizing any awkwardness—the relationship has already been established as a comfortable one—while allowing the provider to be certain that the message is being received and understood, something that might be less likely to happen in a group setting.

Though “training the trainers” was a need expressed by professionals in this research, research in other fields shows that despite having the resources and training, professionals can be resistant to opportunistic health promotion interventions (Nielsen, *et al.*, 2008). The reasons behind this reluctance appear to be multi-factorial and can include the individual’s beliefs and background or even the social setting (Thompson *et al.*, 2008). In this research the work setting of the professionals seemed to be relevant to their level of openness to opportunistic education as well. Youth workers tend to be much more receptive than teachers at Pupil Referral Units or social workers. There is also evidence that the recipients of these interventions tend to respond better to “advise only” services rather than those that push them towards a particular action (Stott and Pill, 1990).

Among professionals there was a consensus that they needed help from as many sources as possible to get information out there to young people. Many would like to see an increase in the number of outreach workers, as this seems to be considered an effective way of providing at the very least some contact information on where to go for more help:

“What we need, God willing, if He ever did provide, is a thousand youth workers on the street and that is one youth worker for three teenagers or one youth worker for three young people. . . . Youth workers like myself we are working hard sitting at our tables writing strategies and going to meetings instead of, you know, getting on the street.” (Prof03, M, black-African youth worker)



Others had ideas for advertising campaigns, radio spots, or magazine columns that might give advice and contact information. Putting up posters in nightclubs and clothing stores that cater to a young crowd was also mentioned as a potential strategy for reaching a greater number of young people. The overall sense was that waiting for young people to seek out sexual health information was not going to work, and that the agency would have to come from somewhere else—parents, schools, the media, and other adults with whom young people come into contact.

Several professionals also mentioned a need for help from religious organisations, or prominent religious officials, in reaching young people whose religious or cultural beliefs might discourage premarital sex:

“Muslim young people, Buddhists and, you know, African cultures, they don't want to hear it . . . they are hard to reach because of their religions and everything and their parents don't want them to hear it but they need to get it. Another group which also proves very dominant is the Catholic groups . . . Catholic schools do not allow us to go in to their schools.”  
(Prof03, M, 25, black-African youth services coordinator)

He went on to describe the positive effect of receiving help and support, as well as the negative effect of a lack of support, from leaders in these communities:

“ . . . some culture leaders who have come in and sort of cut the edge and said look I know these people they're not here to teach bad things. Let's sort them out. I've got a lot of aggressiveness from elders, like a Catholic priest who came and said I don't want to hear this, rubbished our names and things like that but many times even M.P's have intervened. Paul Boatang intervened for us once and said, 'Look; these people are doing a good job. Let's sort them out'” (PE03)

The professionals need for help in reaching out to young people also included some practical concerns like needing more training in dealing with people from different

cultures or backgrounds, and needing culturally sensitive literature in a variety of languages.

One additional need for help mentioned by the professionals had to do with the attitudes of their colleagues. Words like “friendly”, “friendliness”, “welcoming”, and “nice” appeared throughout the interviews when discussing the attitude or appearance of those working directly with young people. Several young people recounted stories of being treated unsympathetically by doctors, receptionists, or other professionals whom they approached for help:

“Basically they looked at you like, in a judgmental way and it was just disgraceful, when you go there you need help and support and that's not what they were offering. They were just speaking to you in a rude manner and telling you, ‘Why are you having unprotected sex?’ and things like that.” (YP07, F, 16, Iranian Muslim)

For both groups the ideal sexual health worker would be open-minded, non-judgmental, friendly, welcoming, and trustworthy. Several professionals mentioned a need for training for receptionists in particular, who are on the “front lines” so to speak and are often the first professional a young person will encounter when seeking help.

Prof10, the manager of the leaving care team mentioned above, took this idea a bit further when she explained that perhaps some sort of counselling should be made available to youth workers in general around attitudes toward sexuality. She told a story of one youth worker who was particularly shaken up when a young woman wanted to terminate a pregnancy at 20 weeks. Though she had been trained well enough to know not to disclose her own opinion, she was nonetheless very upset. Prof10 suggested counselling for the counsellors, “. . . something about understanding yourself and where you’re coming from in these things, what makes you reach the conclusions that you do,

why have you got that perspective . . . (Prof10). Prof04 concurred when he reported that some professionals are afraid to deal with sexually exploited young people, or those who have experienced sexual abuse.

### **5.3.2.3. Young people's needs for help: expressed and implied**

From a young person's perspective, help often means solving a specific situation or concern. For example YP21, the expectant father mentioned earlier, wants to start his own business and is looking for financial help from Princes Trust. Others mentioned similar needs for help in terms of money (getting it rather than managing it) or housing information. Yet for most young people the need for help is often not articulated explicitly, rather it is implied. For example, YP12, a 14-year-old female, was finding it "very stressful" to care for both her epileptic mother and her little brother. When she suspected she might be pregnant, after having unprotected sex with her boyfriend because they were drunk and did not use a condom, she went to her friend's father for help in buying a pregnancy test kit from the chemist. Though she did not express that she needed help in caring for her mother, or help with avoiding unwanted pregnancy, or help with her drinking, the need for help is clearly implied in her story.

And YP16, a 14-year-old white-Irish male who left school because of bullying, expressed some anxiety about now finding himself in a PRU with other young people who were kicked out of school for bullying others. He did not explicitly mention that he needed help, but he showed his anxiety by sharing his feelings towards his new school and his secret wish for adult support to ensure he is not bullied again, especially now that

he is dealing with a class of former bullies instead of one or two like in his previous school.

Young people often described circumstances like those above that indicate a need for help, yet they rarely seemed to recognize it as a need for help. Rather, they seemed accustomed to doing things on their own. One wonders whether this might be a result of the belief that help is not available. For those who had experience with social services, the overall impression was that they were lacking. Some were quite vocal in their disappointment with the services they had been provided:

“They should sack all their workers . . . in every place here there's one or two people that are cool that do their job properly but the rest of them are just there for the dough so they don't really care what happens because at the end of the day they go home where everything's nice, yeah, and they don't know about the situation that you're in because it's not them that's in it. They need people that have lived in the system, that's what they need to do because then they know what it's like to live in the system and for how certain things go . . .” (YP21, 19, M, black-British Christian)

Others appeared less angry but were nonetheless disappointed in the experiences they had had with social services, and many exhibited at least some level of distrust.

There were a few, however, who seemed satisfied with the help they had received—notably two young African males who had emigrated as minors and were living on their own with friends. YP23, a 16-year-old male from Angola, said that he finds his social workers helpful “ . . . because they come to see me, they come sometime twice a month and then I meet them quite a lot and they call me and they talk to me”. And YP22, an 18-year-old male from Eritrea, reported, “I talk to them about everything; they're like a family.” It is probably significant that these young men came here without family, were completely on their own, and had fled their countries of origin because of

the physical dangers of remaining. Before leaving Eritrea, YP22 had witnessed the murder of his parents. Also, neither of them had help from any other sources. Social services had provided them with everything—housing, medical care, money, and advice about schooling and jobs. So it is possible that these young men viewed the services as helpful because it was the only help they had ever received.

Though young people might think of help in terms of assistance with specific concerns, professionals tended to take a broader view of the kinds of help young people need. For many, the notion of help also includes providing a sense of empowerment:

“It’s about education, it’s about acceptance, it’s about raising self-esteem, it’s about raising levels of achievement. And it’s huge and so complex.”  
(Prof12, F, black-British outreach nurse)

Provision of sexual health information, in her view, is only one small part of the complex set of needs young people exhibit. Prof 10, the black-British manager of a leaving care team, seemed to agree:

“We’ve got quite a lot of young men who are just not functioning very well at all, so they’re not managing in education, they’re not managing to get employment, they’re not maintaining themselves on training courses. They’re not able to care for themselves in terms of independent living skills or personal hygiene, cooking, anything like that, they’re not able to manage that. Emotionally they’re fairly, you know, not together really, so the combination of all of those factors means that thinking about wearing a condom when they’re having sex with a girlfriend is not the first thing that will come into their mind.”

In addition to these basic life skills like cooking and looking after one’s self, several professionals described young people as needing help with higher-level skills like seeking employment, managing money, or learning effective communication strategies. Prof09, a white-British health bus operator, advised, “We need to help girls to say

assertive ‘No’s and boys to understand what a ‘No’ means”. Developing skills like these involves ongoing support and is not as simple as solving immediate problems. It is on a different level entirely, and implies some sort of ongoing relationship between providers and those they serve.

#### **5.3.2.4. Help planning for the future**

Though we will discuss the need for a significant other in the next section, it is not entirely possible to separate the need for help from the need for a significant other in terms of obtaining certain types of assistance, particularly those having to do with getting on with one’s life. Those young people who appear to have a reliable adult in their lives, a person to whom they might go for advice or guidance, seem overall to do better in terms of planning for their futures than those who do not.

By its very definition, the category of “socially excluded” implies that the persons to whom it applies are not functioning optimally, or even at all, within the existing society. So one clear need for help would seem to be assistance regarding re-entering mainstream society, particularly in terms of work or education. When I asked where they would like to be in five years’ time, young people in the “hard to reach” group tended to be vague about their plans for the future. When I asked YP19, a 17-year-old Portuguese-British female, if she had any plans for the future, she said, simply: “No”. Others said things like, “Have job, do something with my life” (YP01, 20-year-old black-Caribbean male); “I want to be a business man” (YP02, 17-year-old black Somalian male); “I just wanna earn my money” (YP03, 19-year-old Asian Bangladeshi male); “To be in a relationship, have my own business but not having kids, mostly like having a career and

be with some one” (YP06, 17-year-old white-British female); and “In college or something” (YP16, 14-year-old white-Irish male). Few of them seemed particularly troubled about the future, perhaps because they found the present challenging enough on its own.

The peer educators, in contrast, tended to have much more specific plans in mind. The thoughtfulness with which they replied to my questions regarding their futures indicated that this was an area that had been given some thought, and perhaps even discussed with an adult:

“I am hoping to be in university studying architecture. I won't be settled down yet, maybe a girlfriend.” (PE01, M, 16, black-Caribbean)

“I would have two children, I will have my qualifications in hairdressing, and I want to have home, money, I want to have my own business.” (PE03, F, 16, white-British)

“I am sort of in college doing music production. I am doing music practice; hopefully I should be in the music industry doing my bit maybe on TV.” (PE05, M, 17, Caribbean-black-British)

“I want to do pharmacy, mixing medicine and stuff like that.” (PE10, M, 17, black-African-British).

All of these chosen careers fit well within the social system that is in place, and each person seemed aware of the need to find his or her future position in the order of things. For the “hard to reach” group, however, most of them expressed a desire for a career in which they could be on their own, owning their own businesses, rather than working in the system. The exceptions to this will be discussed below in the section on need for a significant other.

This ties in to what Prof12 said above about working with young people to raise their level of achievement—it seems that in her mind having low expectations of oneself is linked with low self-esteem, which is in turn connected to high-risk sexual behaviours. None of the “hard to reach” young people I interviewed mentioned that they needed help to make a dream come true, to achieve more, or to go back to a mainstream institution of any kind (school, college, work place, etc.). On the contrary, even when they described their desired future occupations (those that had something in mind) they mentioned they would like to work for themselves. This could indicate that they accept their current position in society and do not see beyond their marginalised status.

In fact, of all the young people interviewed only YP21, the expectant father, had something positive to say about receiving the kind of help he needed to refocus his life. YP21 described himself as being independent, a young man accustomed to taking care of himself and relying on no one, and he seemed bitterly disappointed by the poor quality of care he received through social services. Yet when describing the experience he had at First Training, he was uncharacteristically positive: “They helped me; they pointed me in the right direction that social workers should have done a long time ago that they didn’t”. He also mentioned that it was a personal advisor from First Training, rather than a key worker or social worker, who ultimately helped him: “Be a lot to Simon because he was always around...it seems people who should do the job do not and people who shouldn’t do the job will do it”.

Often times the need for help comes down to a need for a significant other to provide not only practical information but also the emotional support necessary to bring about a real change in a young person’s life; this type of guidance cannot be provided by



a stranger or even a casual acquaintance. While that type of help is often crucial in the short term—when a young person needs help dealing with an unplanned pregnancy, or needs money for food or assistance getting into housing—when it comes to their long-term plans and goals they seem to need the kind of help that is only available in an ongoing relationship. Without this type of help it seems likely that their marginalised status will not be overcome.

Overall there seemed to be some significant differences between “hard to reach” young people and professionals when it came to their perceptions of the kinds of help that young people need. Young people seemed somewhat unaware of needing help, whether because they were unaccustomed to receiving help or because they felt they were doing a good enough job on their own. Professionals, on the other hand, expressed a wide variety of needs for help, both for young people and for themselves. This category, Need for Help, included the greatest incongruity between the perceptions of young people and the perceptions of professionals.

### **5.3.3. Need for Significant Other**

Finally, the category *Need for a Significant Other* included all the people who were mentioned by any of the three groups as being important or influential in the lives of young people. This includes not only intimate or romantic involvements, but is also applied to anyone who might act as a main source of influence, motivation or support for young people, such as former teachers, friends, social workers, or outreach workers (among many others).

### 5.3.3.1. Segmented networks of support

Most young people seemed to have their own definition of social capital which often got expressed as ‘network of support’ that might be different for different types of needs. So, for example, when I asked, “Who are you closest to?” they might mention their mothers, but when I asked, “Who is the most influential person in your life?” they might mention friends, boyfriends or no one. And when I asked, “To whom would you go for advice in making an important decision?” they might then mention someone else.

The person with whom they are most comfortable is always a factor in determining what actions they might take in the time of need, particularly when it comes to their sexual health. For example, if a young woman thinks she might be pregnant and is seeking help, she is certain to be aware of the different responses she’s likely to get from her mother and from her friend. When YP09 suspected she might be pregnant she went to her boyfriend before going to a clinic. She explained:

“He was very worried. He was supportive; he did know what to do. He was mostly worried about me cause he knew if I was pregnant my mum would kick me out of the house. I mean she would literally do that and so he was very worried.” (YP09)

Most girls reported that if they suspected they were pregnant they would be more likely to go to a peer than to their mothers because of fears of being judged, humiliated, or punished—as one young woman said: “My mother will kill me!” (YP12).

When it comes to sexual health, most young people made a distinction between where they would go for *information and support* versus where they would go for *help* in dealing with a specific situation. For information and support they tended to go to friends

and/or family members, whereas when they had specific concerns they preferred to go to a health care professional as their significant other who can be trusted—of course, in many cases even if they *cannot* trust them they have no choice under the circumstances. The notable exceptions were those young people who had few significant others in their age group, such as YP22, an 18-year-old black-African male who emigrated from Eritrea. He explained: “But it depends what kind of things. If you want to find out about sexual health you have to go to GP because he's the only one that can help, him or people from clinic or anyone who's like a doctor, the ones that trained so you need to go there.”

Those young persons who had had some experience with negative sexual health outcomes were able to name at least one doctor or clinic where they could go for help. However those who had never experienced a need for help generally did not seem to know where they might go if such a situation arose. Though they had perhaps heard something from a friend, many of them expressed a need for contact information. In light of this, it seems that having some point of contact for such services would be helpful to young people in a general way. For example, one young woman explained to me that, after having met and spoken with me, she now had a contact if she needed more information (YP09, F, 15 years old). It is one thing to say, “I would go to a clinic or something” and quite another to say, “I would go to [Barnardos] and talk to [Natalie]”. Knowing an actual person at a clinic would make visiting much easier for many young people, as the awkwardness would be somewhat alleviated. This might then have an impact on the way they used the services offered.

Perhaps due to this awkwardness around adults, as well as a general absence of adult significant others besides parents (themselves sometimes absent), most young

people prefer to talk to their friends or romantic partners about any sexual health concerns that do not require medical attention. Yet it seems likely that peers, might not be the best possible source of information for young people. In light of this, there are two different paths that might be taken. The first is to encourage young people to seek out more reliable sources for sexual health information, such as nurses and sexual health advisors at clinics. The idea being that obtaining accurate and complete information before engaging in sexual activities might go some way toward preventing a visit to the clinic for help at a later time.

The second idea is to educate more young people in the provision of sexual health information. This is, of course the line of thinking behind the development of peer education, which is seen by many professionals as being especially effective among groups of “hard to reach” young people. For example, Prof10, a black-British female who manages a leaving care team, explained that for those whose religious or cultural backgrounds make sexual health education especially difficult, peer education can be an effective means of providing information in a way that is comfortable for the young person:

“... what you need is somebody who is a young asylum seeker who’s very able and confident about the subject and who sees the value of sex education and you train them up and you help them to help people from the same community.” (Prof10)

Some young people stressed that they would prefer to receive sexual health information from someone close to their own age and with a similar background; someone whose judgment they would not fear. As was mentioned above, there was a sense of being from a completely different generation than most adults, one with different

norms and values, and young people stressed that they would want to be *understood* by those providing information. Peer education meets all of these concerns.

Prof03 took the idea of peer education one step further when he stressed the importance of recruiting help from the community of young people in a more general way by creating a kind of grass-roots system for delivering sexual health information:

“ . . . it’s always harder to get a message through to fifteen or sixty or hundreds of young people . . . Obviously I can’t cover that many young people but I do make an impact, or at least I think I have an impact, on the seven or ten young people that I sit and talk with . . . . [They] go back, sit with their friends and start to talk about sex and say ‘No! That’s not the way it’s done, use a condom’ or ‘No! Why not abstain?’ . . . I don’t want to be the one who’s always saying it. . . . You know, the methods are always getting young people to deliver their own message. They listen to each other; that’s why there is peer pressure. If one says let’s smoke, they all will. If one says let’s not have sex, they might not all do it but a big percentage will.” (Prof03, M, 25, black-African youth worker)

Though many professionals cited the benefits of peer education, only Prof03 had this particular vision of “getting young people to deliver their own message”. It is significant that, at the time of the interview, Prof03 was 25 years old and was from a similar background to the young people he was trying to reach. He was enthusiastic about his work, and seemed to have a deep understanding of the kinds of issues facing “hard to reach” young people. This emerged in the analysis, as his words were the most similar to those of the young people.

Not surprisingly, parents played an enormous role in the lives of young people, whether because of their presence or because of their absence. As has been mentioned, young people from African and Caribbean backgrounds had a greater tendency to report that their mothers played a significant role in their lives, and they were more likely not only to

receive sexual health information from their mothers, but also to report themselves as being “close” or “closest” to their mothers. The central role of women in African communities has long been studied. In an essay describing the role of women in African mythology and religion, Mbiti reports:

“The mother or wife is probably the most important member of the family, the centre of familyhood. So it is said by the Akamba of Kenya for example, “He who has not travelled thinks that his mother is the best cook in the world.” This proverb, while attacking a narrow horizon in life, shows how central the person of the mother is.”(Mbiti, 1988).

In this research, which included several participants of African descent, there was a noticeable difference between young people of African origin and those from other backgrounds when it came to the importance they put on their mothers’ role in making important decisions or discussing important matters including their concern with relationship and sexual health.

Young people from the Muslim community, on the other hand, were more likely to report that they would go to friends or romantic partners to discuss important matters in their lives, rather than their families. This was particularly the case with sexual health concerns, although when it came to other issues they would approach their parents—notably when they had something to ask about or report that was likely to please their parents or make them proud, such as help with schooling or finding a job. This was mostly put down to respect for their parents, though it also reflects the hierarchical structure of Muslim culture more generally, where parents are seen as authority figures and are perhaps not considered approachable. For this group, adults in general were not identified as significant others; they were far more likely to rely on their

peers for information, help, or advice. If they had a specific sexual health concern they would go to a clinic or GP (someone who is trained for the job).

One young Iranian woman mentioned that she wouldn't mind talking to an adult face-to-face about sexual health issues, but only if it was someone she knew. "I think it just takes time for you to get used to the person, it becomes easier and easier the more that you talk" (YP06). Though she did not have an adult in her life with whom she felt close enough to discuss these issues, it was as if she could imagine what such a relationship might be like.

Many young people who described themselves as "white" or "mixed" reported that though they were close to their parents and might talk to them or seek them out when making a decision, they were not likely to discuss sexual issues with their parents. For example, YP14, a 14-year-old white-British female, mentioned that though she might seek advice from her parents regarding practical issues like housing, if she were trying to make a decision about whether or not to have a baby she would talk to her best friend or her boyfriend. And YP15, a white-British 15-year-old female, reported that when it comes to discussing important decisions, "If it's a sex-related I'll discuss it with my friends. If it's job-related and other stuff my dad." So the idea of having a segmented system of support, where one goes to certain people for certain types of help or advice, seems more applicable to white and Muslim groups than it does to African and Caribbean ones.

One of the peer educators, a 17-year-old black-British Caribbean male whose mother is an outreach worker, explains the significance of family in his own life:

"Because my family all know that if I do wrong it's gonna go back to them, and cause I am close to more than my direct family, I am close to

cousins and stuff and grandma cause I lived too at hers for a while. So I know ... you know it's gonna come back to you, can't get away from it. If they know that you are carrying on this way it's gonna affect you, [you] are not gonna be as close to them. And you don't want to be away from.... you don't want not to [be] close to them. You want to stay close to them so how I stay grounded knowing that I've got them going on and on at me telling me that I need to do well.” (PE05)

The picture he portrays of a tightly knit extended family that provides guidance and support stands in stark contrast to the life contexts of many of the young people included in this research. Having a network of people around who care for the young person and expect him to do well has a positive impact on self-esteem, which in turn has a positive impact not only on safer sexual practises but also on all aspects of a young person's life (Longfield, *et al.*, 2004, p36). The difference this can make becomes even more apparent when the life of PE05 is compared with those young people who live alone or with friends rather than with family.

For example, YP20 is a Turkish male who had been living on his own in a council flat for the past several years. As a teenager he developed problems with his parents, moved out to spend some time in the streets, and was later taken into the custody of the social services. He was no longer in contact with his family, and his experience with the social services had been disappointing. He felt repeatedly let down by key workers whose rate of turnover was so high he sometimes did not get even one appointment with them before they had moved on. When I asked him if there was a friend with whom he meets to discuss everyday life stuff, including his sexual health concerns or questions, he replied:

“... Yeah, one or two people I chat to, not really friends, but I do ... I'm settled. I've got my friend. ... I was lucky in a way because I am really good with my teachers. I'm still in touch with a couple of them, my social workers, so it is nice.” (YP20)



One wonders if he kept his connection with his teachers and social workers simply because those people were the only ones whom he had ever known.

When it comes to making plans for the future, the role of parental involvement is significant. As was mentioned in the previous section, many of the “hard to reach” young people had only the vaguest sense of the future; their plans were not well considered, and they had a tendency to envision adult lives that took place outside of the existing social structure. There were, however, a few notable exceptions to this, and a closer examination of those individuals points us to the role their parents or other significant adults might have played in helping shape their future plans.

YP07, a 16-year-old Iranian female, intends to become a physiologist. She also lives at home with both parents and two younger brothers. Her father is an architect and her mother is a housewife. She was one of the few young people who knew what her parents did for a living. Education is stressed in her culture, and careers in health care have an especially high status in her community. This cultural norm might also be partly responsible for YP08’s plan to study psychology and perhaps work with children. Though YP08, an 18-year-old Iranian female, was raised in a single parent household, she came to the UK with her sister specifically to further her education.

YP09, a 15 year old mixed-race female, lives with her mother and a younger brother and sister. Her mother does not work, however she describes herself as being particularly close to her father, a graphic designer. She would like to be a cartoonist, a career not unlike her fathers, and one can imagine the influence their close relationship has had on her future plans.

Sometimes a young person's plans for the future are mapped out with someone other than a parent, as was the case with YP22, an 18 year old black Eritrean male who wants to go to university and study animation. Though he lives alone in the UK and has no family here, he did describe having a close relationship with a social worker that visits him regularly, sometimes as often as twice a month. He is also a devout Muslim with strong ties to the religious community, and has found this experience to be especially helpful to him. Though he did not mention anyone in particular, it seems likely that there are adults within that community who take an interest in his current life and his plans for the future. YP15, a 15 year old white-British female whose mother died when she was 12 years old, also found help outside of her immediate family. She lives with a friend and that friend's mother, and describes them as her "adoptive" family. She hopes to become a hairdresser, which also happens to be the career of her adoptive mother.

One young woman was particularly interesting in this regard, as she had little adult guidance from a parent yet had developed on her own a plan for the future. YP12 lived with her mother, who has epilepsy, and her little brother. Because her mother is not able fully to care for herself, YP12 must care for both her mother and her little brother, as well as herself. It is not surprising to learn that she would like to become a nurse. It is also important to mention that she did describe being close to her friend's father, and said: "He's like my dad basically; he looks out for me". She described him as someone serious, and said she takes his advice.

Upon close examination it became apparent that every young person who expressed a coherent and (at least somewhat) realistic plan for the future also had a significant relationship with a capable and informed adult in his or her life. The opposite

was also true: those that did not have a plan, or whose plans were vague at best, did not have this particular kind of guidance. Instead, they tended to be either completely on their own, or they had relationships with their parents that were estranged.

Among the young people in this research a few young people (8), like YP12 mentioned above, play an adult role in the family. This concept of a role reversal between a young person and the adults in his or her life came up, in some form, in almost every interview. Young people are in need of protection and guidance, and one expects that the adults who care for them will have sufficient financial, mental, and cognitive resources to establish a healthy life for themselves and for their children. Yet for many “hard to reach” young people there is a lack of informed, capable adults in their lives. Those involved in this research were mostly raised in single-parent households, including two girls who lived with their fathers and three boys who lived with their mothers. Though coming from a single-parent household does not necessarily mean a lack of guidance, single parenthood does imply a certain degree of stress for the parent, and is often accompanied by a lack of available financial and emotional resources for the child (Biglan, *et al.*, 1990). Also, being raised by a single parent of the opposite sex indicates that those young people might lack a significant other of their own gender who would act as a role model. This has been suggested to have implications for young people regarding their sexual orientation and certain sexual behaviour as well (Otis and Skinner, 2009).

Along the same lines, some young people described feeling alienated from their parents in one way or another, indicating that living in a household with both parents doesn't necessarily mean the presence of a stable and resource-rich home life. When I

asked YP06, a 17-year-old white-British female, to whom she would go if she had a question about sexual health, she replied:

“I don’t aks anyone about it. I don’t talk to my dad anyways. And my mum, cause my sister got pregnant when was 17, she kept going on about it that if you go like this you're gonna end up pregnant like her. So she thinks I am stupid and I don’t know the stuff but I know but she just think that I feel uncomfortable anyways. I just talk to my friend about it.”  
(YP06)

It would seem that simply having an adult in the household, and sometimes even two adults, is not enough to ensure that young people are getting the help they need from a significant other. What they seem to need instead is an adult who is *capable* of helping them and *informed* about the best ways to do so.

For those young people living alone, whether because their parents are not in the country, because they were kicked out of their homes, or for any other reason, the presence of a capable and informed adult varied according to each individual. Some had virtually no adults with whom they felt close, others mentioned relationships with social workers and key workers who had varying levels of significance in their lives.

For example, YP21 expressed a great deal of bitterness at the failure of the system to take care of him properly—when he was expelled from school at 13 and no other schools in the area would take him, social services failed to find him a placement, even at a PRU. Today he is self-sufficient, and does not like to ask for help or rely on anyone: “Well, if I want to do something I do it myself.”(YP21, M, 19, black-British). At the same time, he did explain to me that if he had a problem or needed advice he had plenty of people with whom he might speak—his mother (with whom he has intermittent contact), his friends, “. . . and my sister, she’s got an answer for everything.” As was

mentioned above, he did find help from a personal advisor through First Practice, and seemed to have developed an ongoing and significant relationship with that man.

#### **5.3.3.2. Significant others and the construct of “hard to reach”**

Though the construct of “hard to reach” will be discussed in greater detail later in this research, it does have some bearing on the subject of the need for a significant other. The world to which policy-makers belong is very much the world of adults—it exists within the prevailing social structure, and might even be said to help shape that structure. Within this structure it is assumed that young people will be in contact with adults in schools, in job-training centres, or in employment, and these are seen as the best venues for reaching them. But when it comes to “hard to reach” young people, this system breaks down. When young people are not in school, do not have a secure relationship with a social worker, key worker or a youth worker and they become “hard to reach”.

Yet, as we have seen above, the presence of even one capable and informed adult—the parent of a friend, a youth worker, a teacher, an older sibling—can bridge that gap. Outreach workers seems to be one group to do this, as they are able to target individuals and provide them with contact information on where to go for more help at the very least. This also seems to be the reasoning behind professionals’ interest in training everyone who works with young people in the provision of sexual health information. If each young person could be provided with a single point of contact it could go some way towards relieving their isolation and reintegrating them into mainstream society.

#### ***5.4. Concluding remarks***

Although the topic of this research was to investigate the sexual health information needs of socially excluded young people, it emerged from the interviews that this seems to be only a fraction of their complicated set of needs, and often takes least priority in the context of their lives. A lack of adults in young people's lives seems to make them more susceptible to being categorized in the "hard to reach" group. They are hard to reach in the community of adults, though most of them do have a network of friends to whom they speak regularly and some of them have parents to whom they are close.

## **Chapter 6: Sexual Health Information Acquisition: Trust, Reliability, and Comfort**

Socially excluded young people have a great variety of needs in addition to their needs for sexual health information, any of which might have a direct impact on their perceptions of need in that area. Because these needs—for information, for help, and for a significant other—often seem to them to be much more urgent than their needs for sexual health information, they have a tendency to take precedence. It is hoped that the examination of those needs might go some way towards providing a more detailed picture of the life contexts of “hard to reach” young people, which might in turn provide a better understanding of how best to meet their needs in general, and their needs for sexual health information in particular.

As was described in the introduction to Part II, within the three main areas of need there also emerged six themes or sub-categories that can be described as factors that influence young people’s preferences for receiving information. This chapter will explore the first three of these themes, which refer primarily to the *acquisition* of sexual health information by young people: whom do they *trust* to provide the information, how do they ascertain its *reliability*, and how easy or difficult is it for them to *access* the specific information they need.

## **6.1.Trust**

A quick look at the transcripts indicates that the word ‘trust’ was mentioned twenty-six times by eleven young people. In addition, many young people described situations and concerns that were related to the theme of trust, and therefore will be included in this discussion, whether or not the actual word ‘trust’ was used. Terms which were used in relation to the concept of trust were ‘private’, ‘I can’t tell’, ‘not to tell’ and ‘confidential’.

### **6.1.1.‘The System’**

It has been argued that young people in general have lower levels of trust than adults (MORI, 2003). A young person’s level of trust might be shaped by past experiences with significant others who breached their trust. Alternately it might be influenced by their peer’s lack of trust towards a certain person or institution.

In every single discussion that I had with “hard to reach” young people, they expressed a deep sense of mistrust towards ‘the system’, or what might be called the ‘adult world’. For some, this was the result of bitter experience—when they found themselves in need of help they had been disappointed by the level of care they received. One interview in which the concept of trust was discussed explicitly involved a twenty-year-old Turkish Muslim male living on his own in a council flat and not in education, employment or training (YP20). He is one of the three 20 year olds included in this research because of the relevance of his experiences to the topic under investigation.

As a child of ten living in Turkey his family told him that they were going on a vacation to the UK. They did not inform their three children of their intention not to return until they landed in UK. YP20 explained how he felt cheated by his parents, who had promised him a vacation but separated him from the familiar places and people he



knew in order to “. . . follow their own dreams”. In his teenage years he developed problems with his parents, moved out to spend some time in the streets, and was later taken into the custody of the social services. He has never seen, heard from, or spoken to his family since. He did not want to go into details but briefly mentioned that: “my family...they let me down”.

When asked about his experience of being looked after by the social services, he expressed himself in a disappointed yet understanding manner:

“... ah I had zillions of key workers believe it or not but most of them just left me after a week. I mean I'd mostly just get a letter that says, 'Hi my name is that and that. I'm your new key worker or new social worker', and I'll say 'Yeah you'll be great' and they'd send me an appointment. Then after, before that appointment time comes, I'd get another letter that he'd left or I'd learn it when I got down there that it has been changed, 'It was only a work relationship nothing personal...'” (YP20)

He then went on to explain the effect this high turnover rate of staff had on him. One can see the similarities between the words he used to describe the actions of his family and those he used to describe the actions of the youth workers, although he seemed to be more forgiving towards the second group:

“It was a real let down but I think that's how the system works . . . especially for young people . . . . In my situation, if you are away from the family and you go that way too far to trust someone, and when you do trust someone and he'd let you down, it really hurts. It really does leave a mark... ” (YP20)

Given his history of repetitive broken trust it is no surprise that YP20 generalises his experiences in the past to construct his view about all forms of relationships in his life. When I asked him if there is a friend with whom he meets and discusses everyday life stuff, including his sexual health concerns or questions, he replied that: “ I have one or

two people I chat to, not really friends, but I do . . . I'm settled. I've got my friend." I said I was curious to know where would he go if he had a health issue, and he responded, "If I had any health concerns mainly it would be my GP or friends that I trusted". One can see that he is again referring to friends, though moments earlier he described himself as having only one friend, a few acquaintances, and some former teachers and social workers with whom he is still in touch. I asked him to explain this further by introducing a hypothetical situation. "What if you had a girlfriend and she got pregnant, what would you do?" He responded:

"If you're saying like I said someone that I slept with and I think she wasn't healthy that would be my GP. I'd go and ask him to send me to a private clinic to get me straight information from a private clinic so it wouldn't go down on my medical records if I do end up with anything. . . . Because if I go to NHS it would go to my medical record, straight onto my medical record . . . for particular jobs and places you do have to have a clean medical record sheet and so it does put you down like a freak . . ."

He seems deeply concerned with the trustworthiness of the person to whom he might disclose his problem, as a breach of confidentiality might, to his thinking, have a negative impact on his future. It seems that he, like so many of the young people I interviewed, does not believe that the system genuinely cares about him. Perhaps because of this, in order for him to perceive a need to reach out for help he would have to have a serious problem. As we saw in the last chapter, this has been reported to be the case for many young men (see also Blake, *et al.*, 1998; Family Planning Association, 1998).

YP20 is a virgin and has not had any sexual encounters yet, thus it is likely he has never been in a situation that caused him real concern. It is therefore difficult to predict whether he might see himself as "at risk" or in need of sexual health information. On the

other hand, he does seem to have pretty established ideas regarding how one's trust might be jeopardised and what the potential price of such untrustworthiness might be. This in itself might be the reason for him not to pursue a relationship, which could be a source of motivation to seek sexual health information.

YP20 fits the category of “socially excluded young person” because he meets the criteria for being NEET. The fact that he is 20 years old and has been in this country for the past 10 years yet does not have a reliable social network is a testament to his level of social exclusion. However, categorizing him as “hard to reach” might not be accurate, as he was recruited for this research through one of his previous social workers. Therefore, he might have a network of support (financial, legal and so on) yet he still lacks the social network he needs to develop trusting and meaningful relationships within which he could discuss his everyday concerns, including his sexual wellbeing, if the need for it arises. Because of this lack of a supportive network, some might consider YP20 and his like as “vulnerable” rather than “hard to reach” (please see Aggleton 2004).

Though he did not explicitly make the connection himself, it was not difficult to see the link between his experience of trust with people who were closest to him (parents) and people who were responsible for his wellbeing legally (social services) and the role these had in shaping his cognition of trust and a trusting relationship. This seemed to be the case with most of the young people I interviewed, who were able to recount a wide variety of experiences that involved broken trust, in one form or another, and the feelings of betrayal that ensued. Many had come to believe that it is best to rely on oneself primarily, then friends, and (only in some cases) family members.

### **6.1.2.The importance of shared values**

The link between lack of trust and the perception of shared values has been well established, thus we might assume that the less a young person shares values with a person, the lesser the trust between them might be (Whiting and Harper, 2003). And, of course, the opposite is also true: the more shared values, the greater the possibility of trust. Perhaps this is why most young people, when asked to whom they would go if they had a concern or an important decision to make, including one involving their sexual health, cited friends and family far more often than professionals:

“That's not something that you'll talk about, you wouldn't befriend them [social care workers] and just start bringing up sexual issues, especially when . . . You don't do nothing; you do them things with the doctor; that's just not something that you'll talk about.” (YP21, M, 19, black-British Caribbean)

When I asked YP21 whether he has ever been to a doctor before because of a sexual health problem, he responded, “No, I went to my mum and my sister. You go to someone you trust . . . like if I have a problem with my woman . . . I will speak to her”. I then asked him what he meant by trust and he replied: “My mother loves me and won't lie to me”.

In the absence of a trusting relationship with a parent, young people tended to seek out friends, including romantic partners, as trusted sources of advice for making important decisions. This was particularly true for Muslim young people, who as mentioned earlier did not feel comfortable talking with their parents about sexual health because it was seen as disrespectful. It was also true of white British or Irish young people who often did not feel they had the kind of closeness with their parents that would enable them to initiate such conversations.

The importance of shared values also becomes apparent when one considers that most of the young people interviewed expressed an interest in receiving sexual health information from someone close to their own age with a similar background, as those were the people with whom they felt most comfortable and least likely to be judged.

### **6.1.3. Trust as it relates to experience**

For many young people, ‘experience’ was cited frequently as a good indicator of trustworthiness. One young person cited his cousin as his source of sexual health information; another cited her best friend:

“[My cousin] always tells me about it [sexual relationships and diseases]. Talk to me further. I'll ask him . . . . He is a big man; he had experience. Or he tells me go to a GP and talk about it, if he doesn't know about it . . . .” (YP02, M, 17, black-African Somalian)

“ . . . my best friend, I have seen her and I am following her footsteps and I feel if I ask her something she would give an honest answer and I feel like she does know because she has learned and she has gone through things that I haven't gone through yet.” (PE03, F, 16, white-British)

PE02, an 18-year-old female, was among the few white British young people who described her mother as a trusted other, and this was largely due to her mother’s level of experience:

“[My mum had 12 children I don't think I could go wrong there asking my mum any questions really . . . . I suppose my mum being a older woman and me being a younger person she's seen more and that's what makes me always confided in my mum, that she's seen more out and about and she knows what it's like a bit more than I do so the information I get of my mum means a lot to me.” (PE02)

This emphasis on experience helps explain why young people often mentioned that they would prefer experience-based education rather than getting information from

professionals who might not understand the world they live in. This came up particularly with regards to teen pregnancy, a subject that several young women expressed interest in learning about first-hand, from young mothers themselves. Most young people also agreed that peer education, at least in theory, is a good idea, though few of them had actually met or worked with a peer educator.

In addition, several professionals mentioned that they believed certain aspects of their pasts made them particularly capable of working with the population of “hard to reach” young people:

“I’ve had experiences of my own. I told you I lost a friend but that’s not the closest I’ve come to experience. I’ve been on drugs and I’ve been taken down that route. When I speak to another young person I know what they are going through, you know, and I am able to speak with the passion. And usually the moment I say I have been there they raise their heads. So experienced based teaching is what they are looking for and usually if I can’t be a teen mum—which in most cases I can’t be—I will get a teen mum to come in and do the talking”  
(Prof03, M, 25, black-African youth worker)

“I think being brought up in a deprived area in a sense made me [able] to appreciate the issues in a sense that I have been there, so I think that helps as well.” (Prof12, F, 29, black-British outreach nurse)

“I am Somali and have been brought up in the same culture and with the same problems. It helps me in understanding this population better.” (Prof01, F, 23, black-Caribbean Somali)

It seemed significant that the professionals rarely mentioned the word ‘trust’ or even referred to the concept of establishing trust with young people, though they did seem aware of the importance of providing a safe and friendly atmosphere with the young people in question so that they would feel comfortable discussing issues of sexual health. Even the professionals mentioned above, who believe their life experiences make them better able to understand and relate to young people, nonetheless did not mention the

word “trust” when discussing this subject. When I began my own interviews with young people this idea was foremost in my mind, perhaps because of my background as a counsellor. I was deeply concerned with getting them to trust me, and I had assumed that the professionals felt the same way. So I was surprised when it seemed they took for granted that young people would trust them, especially considering the low level of trust expressed by most young people towards anyone in ‘the system’.

In general, professionals were cited as trusted others only by those young people who had a relatively small social circle and who had, perhaps, no one else to trust. For example, YP04, an 18-year-old black African who had lived in this country for only a few months and had no stable immigration status and no abode, seemed to have low trust level for any stranger. When I asked him where he would go to get information he replied: “One that I can trust. Doctors, hospital if had a problem”. Unlike YP04, most young people did not mention a doctor, or any professional, as a trusted other. Rather, professionals were seen as someone you might go to with a specific concern, but even so were still regarded with a certain degree of suspicion, particularly regarding respecting confidentiality.

#### **6.1.4. Confidentiality**

One of the more significant trust-related issues expressed both explicitly and implicitly by young people and professionals alike was that of confidentiality. For young people the terms “confidentiality” and “trustworthiness” seemed almost to be interchangeable, so great was their expressed need to be assured that their private lives would remain private.

One young man voiced a concern that having an STI reported in his medical records might impact his future job prospects and employability (YP20, M, 20, Turkish). Another mentioned that he had once given a fake name in a hospital walk-in centre because he was afraid that testing positive for HIV/AIDS might jeopardise his case for seeking asylum (YP04, M, 18, black-African). He was the only person who did not allow me to tape his interview, as he was very worried that participating in this research might have a negative impact on his file. I had met him at a job-training centre, where he accompanied a friend to attend a class. I did not get the chance to ask him why he thought he could trust me, but I think it was because I was a student and was not working for the authorities (these were the topics we discussed in prior him consenting to the research). I took extra care in explaining to him that everything would be confidential and that he did not even have to give me his real name. Ironically, he did, though he left out his surname.

All of this led me to understand that he was being very cautious in his dealings with strangers, so I was surprised when he did not even read the consent form before agreeing to sign it. However, when I explained to him that he needed to sign it he asked me to read it for him, at which point he would tell me whether or not he agreed. When I learned that he had never received any kind of formal education and had a low level of literacy, I assumed this was the reason for his not wanting to read the form. At the same time I realised that perhaps assumptions such as the one I had just made might partly be responsible for his distrust of strangers.

The professionals who mentioned confidentiality all stressed the importance of anonymity and privacy for young people when they want to ask questions, share experiences, or evaluate an educational programme they had been offered. However



when professionals were asked how they might be able to ensure this confidentiality they differed amongst themselves. There was no general consensus regarding *what* should be reported or *with whom* they might discuss the matter further. Evaluating when it might be justifiable to break confidentiality seemed especially difficult for those with less field experience.

This lack of consensus goes some way toward explaining why (in this research) the professionals mentioned that they ‘observe’ confidentiality, and at the same time young people seemed to be aware that if they have a sexual relationship and they are under the age of consent there is a good chance their confidentiality will be broken. In a discussion about confidentiality practices at her place of work, the manager of a sexual health clinic explained:

“... we tell them about confidentiality and that how usually everything they say is completely confidential—we don’t talk to teachers, guardians—but if any information was drawn to us that we felt is putting them in danger we might need to share that information with some other members of the team. But we would never do this without informing them ... that’s very important.” (Prof011, F, white, nurse-manager of a sexual health clinic)

Confidentiality practices seem to differ according to the setting. Professionals who work in healthcare settings were viewed by young people as being more trustworthy than formal, institutionally affiliated educators including teachers, school nurses and other school employees. One of the reasons mentioned for this disparity in levels of trust among professionals was the fact that young people can go to sexual health clinics or get involved in outreach programmes (at youth clubs and so on) without needing to give information about themselves by which they might later be traced. Another might be that there are more explicit rules around confidentiality for some professionals, such as social

workers or those who work in the field of healthcare, than there are for others, such as teachers in an educational setting.

YP09, a 15-year-old mixed-race young woman, experienced a breach of trust at her BETS (the Pupil Referral Unit she just joined) that had to do with expectations of confidentiality. When I asked her whether or not she had anyone with whom to discuss her concerns in general, she said: “I can’t tell anyone because I don’t trust anyone there to be honest”. In this context I took ‘honest’ to mean being honest about respecting her confidentiality, as opposed to being honest about the truthfulness of the information provided. She continued:

“I trust one of the teachers there. But for a lot of them I just keep my mouth shut because I don’t know whose to trust. It’s good for education and everything, but if you, like, want to say to someone . . . I advise to not to say anything at all. . . . One time this boy said something and that teacher told everybody about it [teachers and in the class] . . . he embarrasses you.” (YP09)

At the same time, it is important to consider that for professionals there is a protocol that must be followed regarding breaking confidentiality. One professional explained that might have to alert someone if an under-16 presents with an STI.

“It’s usually a child protection issue, by the way, and if a young person, say, comes to me and it’s pregnant and it’s under the age of 16 my immediate reaction would be did you consent, was your sex consensual, so did you allow to have sex? If it’s the clinic, I definitely call the social services, we’ll investigate . . . [If] a 14 or 13 year old comes to me and they are STI, they do present with an STI, I am going to worry. You know I am going to think an adult had sex with this person; it needs to be investigated.” (Prof03)

Prof04, who works with a population that includes young people at risk for sexual exploitation, explained:

“We’re not forcing people to engage with us, we’re offering them a service, but then if we saw [them] having a sort of a child protection issue and if they won’t engage with us, then we have to call the child protection police team and we might, we have in the past come in to pick them up to take them into protective custody . . . ”

This calls to mind the issue raised in Chapter IV regarding who is capable of deciding what is in the best interests of young people, the young people themselves or the adults who are entrusted with their care. When it comes to the provision of sexual health information, it is easy to assume that more is better—telling young people about loving relationships, though it might leave them feeling judged about their own sexual activity, is not likely to cause them actual harm. However breaking confidentiality, even in cases of possible abuse or exploitation, might indeed place them in a position where they feel they are being harmed—as, for example, if an unsympathetic parent is told of a young person’s sexual activity. Besides, it would certainly damage the trust in a connection that is already only fragile at best.

It was interesting to notice that, though young people by and large preferred to talk to their peers about their sexual health concerns—partly due to the comfort level, and partly due to the perceived confidentiality—when it came to “trusting” the information provided by their peers they seemed less confident. This led me to believe that there must be a distinction between trust in an individual and trust in the reliability of the information provided.

## **6.2. Reliability**

At the time the interviews were carried out I was gradually getting the sense that the issue of trust would emerge as a theme, though the word ‘reliability’ did not come to mind.

However I do recall wishing there were some way I might explore the concept of trust in more depth, particularly as it related to “hard to reach” young people and the variety of ways they constructed their perceptions of trustworthiness when relying on an individual or an institution that provided services and information. Because these two concepts are so closely related, it is useful to make explicit the distinction between ‘trust’ and ‘reliability’ as they are used in this research. Henceforth, ‘trust’ will refer to actual persons and the degree to which they are, or are not seen as honest, caring, and behaving in a way that might lead a young person to believe they have his or her best interest in mind. ‘Reliability’, on the other hand, will refer to the information provided and whether or not it is deemed accurate or truthful. A young person might therefore ‘trust’ an individual in terms of his or her intentions yet not ‘rely’ on the information he or she provides as necessarily being accurate. The opposite is also true: information might be deemed ‘reliable’ or accurate even if the provider is not considered ‘trustworthy’ in terms of confidentiality (among other things).

Though the word ‘reliability’ was not mentioned literally by young people, much of what they did say about the truthfulness and accuracy of the information they received led me to choose this word to describe the meaning conveyed when they talked about their preferences for a source of information and the ways they might evaluate the information given by that source. Terms that were used in relation to the concept of reliability, were ‘reliable’, ‘true’, ‘good info’ and ‘right things’.

### **6.2.1.Evaluating reliability**

As we saw above, young people in this research are most likely to choose someone with whom they have a close and trusting relationship when it comes to discussing their sexual health, getting information, or seeking advice. However, when they are faced with a particular sexual health concern they will go to a doctor or clinic. In other words, young people stated that they will go to a healthcare professional for help in the form of services that those they trust cannot provide.

Because young people tend to discuss sexual health only with those they trust, and because those they trust might not have a high level of sexual health education themselves, I began to wonder how it was that they evaluated the information they received. I asked them why they chose one source over another, and how they knew that source was providing accurate information.

It is easy to assume that young people would believe the information they receive from trusted others would be reliable (in the sense of accurate or true). Somewhat surprisingly, this was not the case. Instead, most young people recognised that the information they received might not be entirely reliable, yet they seemed to feel that it was reliable enough to be useful, either because they trusted that the source had their best interest in mind, or because it was simply the only information available at the time. For example, PE04, a 17-year-old black Caribbean male who talks to his cousins about his sexual health concerns, explained:

“They are not really reliable as in facts, they don't really know the facts 100% but at the end of the day when you are that age. . . they've got more experience, yeah? . . . they are family, they don't want you die or bad things happen to you, so they might not know it but they can tell you something wrong. But they are still trying to help you.” (PE04, M, 17, black-Caribbean)

Also it seemed the more trust they had in the source the more likely they were to rely on the information provided, despite knowing that the information might not be the most factual.

Experience, which was discussed above as a factor in establishing trustworthiness, could also be a factor in determining reliability.

“She's had 12 children I don't think I could go wrong there asking my mum any questions really.” (PE02, F, 18, white-British)

“[My cousin] is a big man; he had experience.” (YP02, M, 17, black-Somalian)

“Well, as older peers [my friends] have more knowledge about things and they obviously are in college before and some at uni and things like that so they're gonna learn a little bit more and you don't take all the information they give so you take out things you want. So I probably research on it more.” (PE07, F, black-Caribbean)

When I asked PE07 to elaborate on her way of researching into it she responded, “I will ask around. If a few people said the same thing then it is the right info”.

Several other peer educators mentioned using a similar method of consensus as a way of establishing the reliability of information they had gathered from friends. They would ask around, and if they received the same answer from several sources then they would assume the information was correct. Taking a consensus was not mentioned, however, among young people in the “hard to reach” category. One reason might be that the “hard to reach” young people generally seemed to have only a few friends and acquaintances, while the peer educators had a more extended circle of social support around them. Also, because peer educators have been through a course in sexual health, they may be more confident and articulate about putting their questions forward:

“... [if I have a question I will go to] Brook, I would go to clinic, I'd aks my friends. But I am not ashamed of to aks anyone at all. Anyone

that can help. Even a young person might still teach you something you might not know. You know like what I am saying, so anyone basically.” (PE04, M, 17, black-Caribbean)

PE04 mentioned that as a part of the training to become a peer educator he went through courses where he role played, which may have helped him to be more assertive in seeking out information. Also, peer educators are constantly being encouraged to be open and talk to their peers about sexual attitudes and behaviours at every opportunity; this is a part of their job. So their level of comfort in asking questions or in talking about sexual health more generally might be assumed to be greater than young people in the “hard to reach” category, who have not had the same experience.

One of the rather astonishing findings that emerged in this section of analysis was that not all peer educators mentioned that they would go to their mentors in the clinic to check upon the accuracy of the information they received. I had assumed, incorrectly, that now that these young people had access to professionals whom they saw as knowledgeable at least about sexual health, this would be the first place they would go with questions or concerns. Yet when speaking of themselves as young people, not as peer educators, they seemed to be more like their counterparts in the “hard to reach” group—that is, they preferred to discuss things with their friends. It was significant, however, that when they had their ‘professional’ hats on and were speaking to me as peer educators they were clearer as to where to go for information to support their work. They mentioned that there were always two of them in a session, and they also had a mentor one call away to help them with any questions they might not be able to answer. Yet taking advantage of their mentors’ knowledge when it came to discussing their sexual

health as young people was not foremost in their minds. I wonder if this could be because they did not want to be seen as one of young people in the eyes of their mentors.

Of course, most “hard to reach” young people do not have ongoing, trusting relationships with sexual health workers; more often than not, their social circles are relatively small, and most would not describe themselves as being surrounded by a network of support. The relationship between having a large social circle and being able to find the answers to one’s question was put clearly by PE01, a 16 year old black Caribbean female, who said: “. . . if you have a big group of friends, there is always somebody that knows something about things that you don't know about”.

For those without a large social circle, it would follow that reliability is harder to determine. For example, YP04, an 18-year-old black African male who has no immigration status, no housing, and has only been in this country a few months, would not have anyone with whom he might cross-check information he heard from friends. The same might be said for YP20, the young Turkish man who lives alone in a council flat, or for YP23, a 16-year-old asylum seeker from Angola who shares a flat with five other young people. It is likely that those five flatmates might be the only available people with whom he could check information. We cannot assume that all young people have access to someone from whom to acquire the information in the first place, let alone having access to more than one person to verify the information they receive.

In fact, for many “hard to reach” young people, their preference for receiving information from a trusted other might have something to do with the fact that they are the only available source of information. Though they might prefer someone more knowledgeable, they either do not know anyone offhand or they do not know how to get



access to such a person. Many young people mentioned that though their peers might not be the best source of information, in reality their friends are the only source they know. It seems they learn that they have to rely on something or someone in the end to give them answers to their questions. One young woman told me that she cannot be sure of the reliability of the information nonetheless, she goes to her friends for information because “. . . you have to trust someone” (YP14, F, 14, white-British). A similar idea was mentioned by PE11, a 17-year-old black Caribbean male, who explained, “It’s have to come to Brook. If I did not know Brook I don’t know. I had to ask my mum for help and advice . . . if she didn’t know I don’t know, I’d just be silent and told no one!” I asked him if in this situation he would have gone to his friends; he replied: “Yeah, you got certain friends that you can aks certain things. I do have a friend that I can turn to in that sense”. Yet when I asked if he felt he could rely on the information he might receive, he said: “You just don’t know. You can’t put 100% trust in one person because there is not that full 100% of trust but you have to go with your instinct when you trust them.” Again trusting the source comes into play.

Although most of young people and peer educators mentioned trusted others as their primary sources of information, in a few cases they also referred to books, magazines, and the Internet as potential sources. By and large books and magazines were viewed as more reliable than the Internet, as it was assumed that something in print must have been produced by someone with a certain degree of credibility. However most “hard to reach” young people did not themselves use these sources for a variety of reasons. Some did not

like to read at all, others did not want to read anything too long or difficult, and many did not have regular access, or any access, to the Internet.

### **6.2.2. Professionals as reliable sources of information**

Though young people remained somewhat suspicious and untrusting of ‘the system’ generally, they all reported that they would go to a professional for help, whether a GP, a nurse at the Pupil Referral Unit, or a sexual health clinic. They appeared to be confident in the reliability of the information provided by professionals. For example, when I asked them “Which source of information do you think is most reliable?” or “Who is the best person to provide information on sexual health?” almost all of them mentioned an adult who has been educated in sexual health. Though they might not feel the healthcare provider is trustworthy, especially in terms of confidentiality, they nonetheless believe the information provided by a professional will be the most reliable.

It seems that, for many “hard to reach” young people, trust and reliability are rarely found in one person and sometimes appear to be mutually exclusive. Those they trust might not have the most reliable information, yet those who are reliable might not be trustworthy. This highlights the divide between “hard to reach” young people and mainstream society. Whereas peer educators, who are arguably more connected to society, seem more likely to have trusting relationships with informed and capable adults—such as teachers, youth workers, older friends who are in university, even parents—“hard to reach” young people do not. Instead they remain firmly ensconced in the world of other “hard to reach” young people, who seem to have the same levels of information, or misinformation, as they do themselves.

Though several other young people also mentioned the word ‘trust’ when referring to professionals, upon close examination of the text it became clear that they were actually referring to their ability to trust the information or services provided, not the individual in question, thus in the end it was reliability, rather than interpersonal trust, to which they were referring. YP09 was one of the few “hard to reach” young people who expressed some level of trust for a professional. Another was YP10, a black-Caribbean, 19 years old, British female:

“Then you aks, you aks the adviser in GUM clinic the next time you go in there. You know there is lots of silliness you know like you can’t get pregnant for the first time. If some one told you that maybe you aks about it. I would aks my mum but you could go the next time you see your advisor or your PSE teacher you could aks, that would be for younger people like my sister going to school she is easier sort of to stop her in the corridor and aks her.”

It is important to point out that YP10, unlike the majority of “hard to reach” young people, already has an established relationship with a sexual health worker at the clinic where she goes several times a year for birth control injections. So, for her, verifying information with a sexual health professional is not difficult, as she already has access to such an individual. This is not the case for most socially excluded young people, who experience a gap between finding someone to trust on an interpersonal level and finding someone who can provide reliable information.

### **6.2.3. Bridging the gap between reliability and trust**

For many professionals, one strategy for bridging this gap between trust and reliability would involve educating other professionals in the provision of sexual health information. As was discussed in Chapter Four, if all adults who come into contact with

“hard to reach” young people were trained to provide sexual health information then there would be a greater likelihood that the young people would be able to receive reliable information from someone whom they also trusted, provided such a person existed.

Parents were also mentioned a potential resource for providing reliable information in a trusting environment, especially by professionals with black African and Caribbean background. For this group, parents (and other adult family members) were seen as having a responsibility to educate their children:

“... in my background always parents talk to their children about sex and sexual health ... there are certain cultures within them they are expecting aunt or uncle to talk to the young people. What I am feeling more and more is that these traditions are not followed ... I think there is a huge gap between young people and parents.” (Prof12, F, 29, black African-British outreach worker)

Her suggestion to fill this gap was “... to educate parents about how to initiate these conversations”. Of course, not all young people, would prefer to receive this information from their parents, yet educating parents might go some way towards ensuring that those who do choose to approach their parents would be getting information that is reliable.

Given that young people tend to trust other young people, it would also seem that peer education might go some way towards bridging the gap between trust and reliability. It was surprising, therefore, that few of the professionals stressed the importance of this source of information, though those who discussed it all agreed it was a good idea. In fact, only Prof03 expressed a particular interest in taking maximum advantage of the relationships young people already have with one another as a means of disseminating sexual health information.

#### **6.2.4. Professionals' views of their own reliability**

By and large professionals seemed to take for granted that they were seen as reliable sources of information for those young people who sought them out. Yet some of them did express concern over whether or not they would be able to answer all of a young person's questions. Prof03, the youth worker cited above, and Prof10, a manager for a leaving care team, in particular believed that this is an important issue as a professional might only get one chance with a young person and if they are not able to answer the young person's question then it will remain unanswered.

Many of the professionals expressed that they have felt challenged in their jobs because of religious, cultural, and language differences, which at times posed a barrier in their process of work. However, almost all of them mentioned that if they did not know an answer they would say so. Some would go with the young person to seek out the answer, and others would ask the young person to come back once they had found the answer. A few also mentioned that they would prefer to work as a team, with a youth worker and a nurse running sessions together, as between them they could find the answer to almost any of the questions that young people might have:

“I am young, I know what they [young people] want. An ideal situation is to go to them and have a back up so if you have a question [regarding medical facts] they can support you.” (Prof03, M, 25, black-African outreach worker)

Such a system would go some way toward reassuring at least some professionals that they can offer accurate and timely information to young people.

However, this kind of support is often not available, particularly in outreach settings. In fact only one youth worker, from Brook, mentioned that he had a back up

member to support him in case he came across a question for which he did not know the answer. For Prof03, not having this support makes his job more challenging:

“I think I'm an angel. I think I can do so much and very many times I get out spotted, out done, I get too tired . . . I've been asked questions and I just don't know the answer and I've gone back to school, or I've gone back to training. One of my other biggest problems like I said is still around support. I feel the youth services under the council can do a whole lot more.”

He then made the point that if he had someone to whom he could reach out for the facts he would be able to focus on what he does best—connecting with young people and delivering information—without having to worry about the reliability of the information he is providing.

### **6.3. Comfort**

The theme of comfort, which is closely related both to trust and to reliability, emerged as a significant factor that inhibits young people from seeking out sexual health information. Sixteen young people mentioned the word ‘comfort’ twenty three times in total. They seemed to use this term mostly in relation to certain individuals, including professionals, to whom they might go to acquire sexual health information or help. Terms used in relation to the concept of comfort were ‘comfort’, ‘comfortable’, ‘easy’, ‘embarrassed’, ‘shy’, and ‘uncomfortable’.

#### **6.3.1. Gender, culture, and religion**

As we have seen, by and large young people do not like to talk about their sexuality with anyone other than their closest friends and confidants. Though they will go to other sources when the need arises, such as doctors, nurses, or youth workers, they mention

comfort as an important factor when evaluating these experiences. As might be expected, the extent of their discomfort seems to be related to gender, ethnicity, and cultural or religious background.

In my own research I often found young men to be less forthcoming in talking about their sexual health; they had a tendency to give short, one-word replies to my questions and gave a general impression of discomfort. Many of the professionals corroborated my experience, and explained that it is often difficult to connect with young men:

“Boys are always harder to reach than girls are because boys are either ashamed to speak of sex obviously with another adult or, you know, they prefer to talk about it with themselves.” (Prof03, M, black-African outreach worker)

“I've got male friends they don't feel comfortable to go there and talk to someone about it, even if they are dying they rather just to go through it than go to a clinic, if they don't feel comfortable going there.” (PE06, F, 17, black-African)

The single exception among professionals was Prof09 (F, 29, white-British outreach nurse and health bus operator) who reported that they recruited more young men in their services than women. She attributed this to the mobile nature of the health bus that could travel to locations where young men tend to be (Edgecomb, *et al.*, 2003).

Young women, by contrast, were often quite talkative throughout my own interviews and were likewise described by the professionals as being generally more receptive to discussing sexual health issues. This is not to say that they are immune to discomfort, but only that they seemed to be able to seek help and advice despite any embarrassment they might feel (this did vary between young women from different backgrounds).

Though most professionals said that they give the same information to males and females, quite a few expressed a preference for conducting single-sex sessions. Prof12, a 29 year old black British outreach nurse, explained:

“ . . . in some mixed groups you get some girls who go very quiet because they are shy around boys. And the boys play up to impress the girls, so if you split the group maybe you'd get a more honest and focused session.” (Prof12, F, 29, black-British outreach nurse)

Several young people, particularly females, also expressed an interest in single-sex sessions, as they believe they would be more comfortable with members of their own sex. YP19, a 16-year old-Portuguese-English female, disclosed that during an SRE session, “I didn't put the condom on when they were teaching us because it was like putting condom on a boy and you didn't really want to do that.” One can easily see how she might have felt uncomfortable in that situation, and a single-sex session might have gone some way to alleviate that.

Young people from black African and Caribbean communities, particularly those with strong family ties who had discussed sexual health with a parent or other adult, expressed shyness or embarrassment less frequently, in general, than those from white British backgrounds. However, young people from a white British background who had discussed sex with their parents or with another adult, such as the mother of a friend, also expressed less discomfort about the subject than young people who had not had such a conversation, and were less likely to cite embarrassment as a disincentive to seeking out sexual health information or help. This comfort level seemed to be the case for most young people who had a caring relationship with a trusted adult, regardless of their



background—as if, by engaging a young person in a discussion of sexual health, the adult had granted permission for that young person to discuss it more freely with others.

Young people from observant Muslim backgrounds often expressed discomfort when discussing sexual health issues. This was particularly true for those who had emigrated from countries with cultures that are deeply rooted in Islam, as opposed to those who were born and raised in the UK. Two of these young people had had bad experiences at sexual health clinics, which they disclosed to me. YP23, a 16 year old asylum seeker from Angola, explained that he had gone to a clinic to get condoms for a friend:

“There she was one girl, and she said to me about, ‘Why do want condoms, what you will do with condoms?’ and I think it was stupid question, ‘What do I do with condoms’.”

When I suggested that perhaps she was only trying to ensure that he knew how to use them properly, he replied:

“Well no, the way she said it, no, ‘How you need it!’ it was like, you know, maybe more slowly, take it easy, but no the way she said, ‘Why you need it!’, it make me, like, ‘Wow, why she want that?’. I was, like, *shy*, you know?” (YP23)

And YP07, a 16 year old Iranian female, described her experience at a family planning clinic as follows:

“Basically they looked at you like, in a judgmental way and it was just disgraceful, when you go there you need help and support and that's not what they were offering. They were just speaking to you in a rude manner and telling you why are having unprotected sex and things like that . . . . And they gave me like a stash of condoms, they gave me like about 24 or something like that, and I told them that you know I don't need all of this, and they were like, ‘No trust me, you're going to do it again and again, you do need it’, like as if to say, ‘I know that you do these things all the time’, you know?”

Stories like these underscore the importance of providing services that are friendly and welcoming. YP07 mentioned that in the future, if she is in need of sexual health information or help, she would not go back to that clinic because of her experience there, but would instead try to find: “. . . a nicer one”.

Establishing a comfortable atmosphere with “hard to reach” young people from different cultures, specifically those that are more private about sexuality, was described as challenging by several of the professionals. The groups mentioned included Muslims, Catholics, and those from African or Asian cultures. Prof12, a 29-year-old black British outreach nurse, brought up the issue of respect towards the young people she serves, especially those who come from religious backgrounds with which she is not familiar. She explained that if, during a group session, a participant raises a concern about the acceptability of discussing sex in her culture, and explains that she does not need the information, Prof12 will respect the judgment of that individual and will not push her into receiving information that makes her uncomfortable:

“I would trust them and I do appreciate that even within religious groups there are maybe not religious beliefs but there are cultural things, they tend to blur. I can’t say, ‘No, you’re wrong’ when they say something. I mean, my expertise is sexual health and I always say that this is my expertise and I know that you know many things already but let me fill in the gaps.”

This seemed to have helped her to establish a dialogue with young people from religious and culturally diverse background that enabled her to convey the information she felt they needed.

Prof10, a black British manager of a leaving care team, took this idea one step further by explaining that she will respect a young person's right not to discuss sexual health with her at all:

“There are some young people that we work with [who] wouldn't want me to sit there to talk explicitly about sex with them, cause that wouldn't be appropriate. . . . So it's about trying to find some way of negotiating that and understanding that without sort of railroading them, without indulging in some form of kind of modern day imperialism by saying you know ‘This is what you must have because that's what all our young people over here have’ . . . . But then equally if I were confronted by somebody who was born here and didn't have any sort of religious objections to it but just said, ‘Listen I'm not interested in talking to you about sex, mind your own business’ I'd have to respect that as well.”

She went on to explain that she tries to ensure that all of the workers in her leaving care team are trained to discuss sexual health issues, whatever their specialty, as she believes that this is often the best way to manage the young person's discomfort. In this way, any adult with whom a young person bonds will be able to provide them with the information they need.

### **6.3.2. Personal inhibitions to accessing services**

Some young people mentioned that they have personal inhibitions that prevent them from accessing the information and services. For example, a few expressed concern about being HIV positive, particularly young people of African origin who recently moved to this country. For YP22, an 18-year-old male asylum seeker from Eritrea, his fear of getting a positive test result kept him from going to a clinic. He explained:

“... I do have some concerns, I've never been to hospital to get checked about anything, about AIDS, but I'm saying that everything is normal about my body, but I was wondering whether to go and get checked but I think everything is okay . . .” (YP22)

When I asked him why he hadn't been to a clinic to get checked, he explained:

“... because sometimes you don't feel comfortable talking about these things, especially when you haven't been tested because you know you always think there's a chance that I might have it, so you just want to keep it to yourself.” (YP22)

YP22 seemed to be having an ongoing internal dialogue with himself. On one hand, he is worried about the possibility of having a potentially deadly virus; on the other hand he is trying to calm himself down by telling himself that it is not serious because he does not feel sick. I asked him if he had been tested for HIV when he first came to UK (as a routine test for all unaccompanied minors entering the system of care), he was not sure. He also seemed reluctant to go to a drop-in GUM clinic to be tested. One hypothesis might be that he is still not confident enough to go to a service on his own. Although he has been in this country for the past three years, he was in a protective system and did not have the chance to explore the social system (including health care) that well. Another factor might have been his confidence in being able to communicate with other people in English. The fact that he is still an asylum seeker might come into play too. Although he did not mention that being confirmed HIV positive would affect his status, other asylum seekers did mention it as a concern. YP04, an 18-year-old black African from Somalia, explained: “Yeah, I've been to GP for initial test for my documents... I was like, what if I get HIV... they can refuse your application you know, you have to be clean, no crime, drug”.

My experience with YP22 led me to question whether perhaps other young people had similar highly personal reasons for not accessing sexual health services. It

seems that, for some young people, they would prefer not to know their sexual health status, rather than receiving a positive test result and having their worst fears confirmed. Reaching out to young people to reassure them that knowing is better than not knowing might be an area for further exploration.

### **6.3.3. Sexual health as a taboo subject**

Several professionals expressed the opinion that discussing sexual health can be uncomfortable even for adults:

“It feels like we do sex in the media and everywhere, [yet] actually talking about sexual health and talking about young people’s sexual health is just, it’s still a bit of a taboo subject, which you know needs to change I think. I think sex is in the media all the time, that we need to talk about sex, and what is good sexual health and poor sexual health, and where you go for support.” (Prof04, M, white-British manager of youth outreach programme)

He appeared to be making the point that, as a culture, we are uncomfortable in dealing with the issue of the sexual health of young people, which in turn could contribute to young people’s reluctance to seek out sexual health information. Their fears of being judged may be realistic.

Along the same lines, Prof05, a 56 year-old white British male who had initiated sexual health text messaging services for young people in 2008, said that though he would like to produce a video for young people he has not done so yet as he understands his distributors would be reluctant to carry it as a product. He put it as: “It is too controversial”. He then explained as why their text messaging service had to close down after only few months: “it is not financially feasible...we are essentially a commercial organisation, not a health education charity, these things don’t pay back”. His observation

about the controversial nature of teenage sexuality does shed some light on the ways that comfort levels might be impacted by the attitudes of the general society, thus the decisions of potential providers of information to this group.

Several young people, for example, mentioned that when they had received SRE in school the teachers seemed uncomfortable with the subject matter and rushed through it, or simply handed out leaflets and gave the students a moment to read through them but did not follow up with any lecture or question-and-answer session. For this reason, among others, many expressed a preference for receiving SRE from someone outside the school setting, ideally someone who is specifically trained in delivering sexual health information. For example, YP19, the 16 year old British Portuguese female mentioned above who did not want to engage in a condom demonstration during a mixed-sex session, explained that eventually she did learn how to use a condom. She said: “The first time I did it was in my college. I don't think the teacher was even watch us. They just left us with it.” She went on to explain that she also doesn't like to talk to her doctor about sexual health issues as he seems uncomfortable. Instead, she said: “I go and talk to the nurse because sometimes you feel the doctor might not be comfortable so sexual health clinics is better cause they're trained in that. They use to be questioned about that you feel more comfortable asking about them”. It would seem, based on comments like these, that young people are able to “read” adults in terms of their own comfort levels, and prefer discussing sexual health with those adults who are most comfortable with the subject.

#### **6.3.4. Establishing comfort: the professionals' view**

The majority of professionals appeared to be sensitive towards the (sometimes extreme) discomfort young people must overcome in order to discuss sexual health, and most made a concerted effort to diminish this discomfort as much as possible. Prof11, a 39-year-old white British nurse who manages a sexual health clinic designed specifically for young people, explained that the clinic was created as an alternative to other health services in part as a way to address this discomfort:

“... young people tell us they were afraid the clinic was not confidential enough for them and because we have a very local population, they found that sometimes they were here and a family friend or mother's friend were in the waiting room so it made them uneasy and left for those reasons. They said they needed some protected space so that is why we set up the [name omitted] clinic.”  
(Prof11)

She went on to explain that providing a friendly atmosphere is important in the clinic, and cited research (conducted both at her own clinic and elsewhere) that underscored the importance of friendliness to young people. Several other professionals in this research made similar observations.

Though this might seem to be an obvious need, this kind of friendliness is not always provided, as we saw above with YP23 and YP07, both of who had negative experiences at sexual health clinics. Prof03, a 25 year old black African youth worker, was quite insistent on this account, and explained:

“We have services but my one question is are those services delivering? Are those services youth friendly? . . . . One-stop shops need to have much smilier people, people who are really nice to young people. Cause some of them are afraid of walking to that hospital there'd be that woman who would just kick me out. You see so yes, there might be a hundreds of services but they don't have the staff that are nice enough to work with young people . . . ”

This sentiment was echoed by many of the professionals, some of whom, like Prof11, stressed the importance of providing more training to the reception staff in order to ensure that young people are greeted and made to feel welcome.

Among the professionals, youth workers seemed to be more conscious of, or at least referred more often to, the importance of establishing a comfortable atmosphere before trying to discuss sexual health.

“I talk about it as if it was natural. I say the word ‘sex’ as if I was saying ‘water’ and that’s what you need to do. Let them laugh for a couple of minutes. The first fifteen minutes it’ll be a joke. Then say to them, ‘Look, guys, now it’s serious work’” (Prof03, M, 25, black African youth worker)

“Initially I do ice breakers, something quite fun, they like that. And then I’ll tell them it’s okay to be silly, it’s okay to be silly and laugh. We will make them as relaxed and safe as possible . . . They usually enjoy the sexual health sessions. They are thinking about it, their hormones are raging, so sex would be on their mind any way. As long as it doesn’t make them uncomfortable talking about these issues they are happy to talk about it.” (Prof12, F, black-British outreach nurse)

Prof12 also made the point that she tries to end the sessions ten minutes early so that those who might be uncomfortable raising an issue in front of their peers might be more likely to approach her privately. Several other professionals also will end sessions early, if time permits, so that they might be approached in private afterwards.

Prof03 (M, 25, black-African outreach worker) stressed exploring the possibilities of anonymous services, such as call-in centres, as a way to deal with a young person’s discomfort in dealing with an adult face-to-face:

“. . . young people love to speak to people they can’t see. ‘Hello, good afternoon, I want to find out if I’m pregnant. I had sex and I didn’t use a condom.’ ‘Well if you are pregnant, you might need to . . .’ She’ll be comfortable. But sitting in front of me and talking to me she’ll look at the floor, she’ll be embarrassed, and she’ll swear to God she’ll never come back there.” (Prof03)



He went on to explain that in his experience young people are eager to learn about sexual health if they can do it on their own. “You see, so telephones, internet, computers, C.D's, things like that. Those resources, more and more resources that young people can use on their own that are easy for them to use on their own to teach them. They have asked us to develop. They say: ‘Please, give us more of that’ ”. Though providing access to such self-directed material presents its own challenges, information of this type would help with the discomfort of face-to-face sessions.

It may be significant that many of the youth and outreach workers, like Prof03 and Prof12, come from backgrounds similar to those of the “hard to reach” young people they serve. Most seemed genuinely to enjoy working with young people, to relate to them, and to welcome their questions and concerns, and it was not hard to imagine that they would be very well received as sexual health educators.

Yet it often seemed to me as I conducted this research that the higher up the administrative ladder, the less likely it was that professionals had this kind of rapport with young people. Though all were aware of the importance of providing a comfortable atmosphere, there were nonetheless very subtle differences in how they spoke of their work. For example, Prof11, the 39-year-old nurse manager of a sexual health clinic mentioned above, explained:

“The most important thing is that we need to be friendly. We need to introduce ourselves, it's important for them to know whether we are a doctor or a nurse . . . . Then it's just start of a bit of a rapport and then I sometimes say, ‘I've seen you before, well-done to get here’, because it's important that they don't feel that you judge them . . . . We know from research that has been done here and in Brook advisory centre that confidentiality and smiling and being friendly is most important.”

Her choice of words, “it’s important that they don’t *feel* that you judge them”, stresses the young person’s *perceptions* more than the *actual feelings or attitudes* of the provider.

Whereas the youth workers mentioned above seem genuinely to enjoy young people, the professionals referred to here need only to *appear* friendly because the research shows that this is important to the young people with whom they’re dealing.

Of course, it seems likely that Prof11 also does genuinely like working with young people, as working with them is her chosen vocation, and the same probably can be said of everyone in this field. But the more responsibilities an administrator has, the less time he or she seems to have to actually speak and interact with young people. Perhaps this is one of the reasons why so many youth workers and outreach workers expressed an interest in helping to design the material that goes out to young people—they feel that they are much more in touch with what their world is like, as they are in contact with young people every day.

### **6.3.5. Young people’s perceptions of comfort**

Young people, for the most part, expressed a great deal of interest in receiving sexual health information from someone who could relate to them—not too much older, and from roughly the same socioeconomic background as themselves. They fear being “talked down to” and being judged, and seem to feel that this is less likely with someone closer to their own age and experiences.

They also by and large seem to prefer talking to someone one-on-one, or in small groups, as this might lessen their discomfort and enable them to ask questions. Smaller groups also tend to be more interactive, and many young people expressed a preference

for interactive sessions as opposed to the types of SRE lectures they may (or may not) have received in school. They seem to believe that in a small group they will have better access to the information that is most relevant to them at that particular moment.

When asked whether they would prefer to go somewhere to receive the information on their own initiative, or whether they would prefer to be approached by an outreach worker, their answers were highly individual. Those who appeared relatively confident about discussing sexual health might prefer to go to a clinic (though few of them actually seem to do so), but many others would prefer to have the provider take the initiative:

“Yeah I think they [professionals] should talk to you. I think teenagers should be able to talk to people more about it, cause I don't think many people feel comfortable talking about it, so you should come to us and talk to us.” (YP13, F, 15, white-British)

“There is nothing really wrong with the information available, it's just a lot of young people are scared to come to the clinic, cause they have a ego, like, if I go there oh they're gonna lose their reputation; they don't feel comfortable questioning.” (PE06, F, 17, black-African)

Prof09, an outreach nurse and health bus coordinator, believes that the health bus is an almost ideal situation:

“It is good to offer these services in buses because it is not at school, it is not disciplined, they can attend with their chosen friend and its voluntary attendance. Small groups of friends are very good we can go through lots of things. They usually don't ask, they're shy, so we start by asking them about their understanding of relationship and then move on to the next level up to the level of the individual's understanding. We usually start by referring to the leaflets material that we gave them and start asking questions like, ‘Do you know about...’ and ‘Do you want me to explain it to you?’. We are not lecturing them . . .” (Prof09, F, white-British)

At this point, the burden of providing comfort seems to fall on the professionals, as the young people just would not access the service if they do not feel comfortable doing it.

#### **6.4. Concluding remarks**

If we were to choose one point as the most prominent underlying contributing factor to young people's inhibition in acquiring the information and services that are available to them, it would probably be having a source to go to, a point of contact, with whom they feel comfortable. Ideally this would be an informed and capable adult, someone with specific training in providing sexual health education.

When I began the interviews I had thought that distrust would emerge as the biggest concern young people had, and would be the primary factor in prohibiting them from approaching a source for information. To some extent this seemed to be the case, as young people will seek out information from a source they trust, whether or not that information is seen as entirely reliable. For those who live alone or have no stable relationships, trusting anyone at all might sound like a luxurious next step.

When young people have no other sources to which they might turn, they learn to rely on the information provided by the people around them. It is only when this help and information is insufficient, when they have an actual problem that requires a more reliable source of help (in terms of accuracy of information), will they seek out a professional. The issue of interpersonal trust, even the issue of confidentiality, seem to take a lesser precedence in these cases, given the circumstances that motivated them to seek help in the first place. An ideal situation would be to find a source of information that is both reliable and trustworthy.

Given the wariness with which "hard to reach" young people approach adults, who comprise the whole spectrum of providers from policy makers to youth outreach

workers, it seems important to consider alternative sources of sexual health information. Yet because young people would, in most cases, prefer to ‘talk to someone’ in person, it likewise seems crucial to explore the possibility of replacing this distrust with constructive, trusting relationships with informed and capable adults. Only then will the gap between reliability and trustworthiness be bridged.

Though young people did have a lot to say about their own comfort levels around discussing sexual health, the overall impression was that the burden of establishing comfort seemed to fall on the professionals’ shoulders. The implications of this, and recommendations for moving in this new direction, will be explored in the discussion section of this research.

## **Chapter 7: Provision of Sexual Health Information: Accessibility, Helpfulness, Quantity/Quality**

This chapter will discuss the main themes that emerged as being relevant to the provision of sexual health information, which include the *accessibility* of sexual health information for young people, the *helpfulness* of the information provided in terms of whether or not it responds to the needs of young people, and the *quantity and quality* of this information in terms of its content and the amount of time allotted for its provision.

### **7.1. Accessibility**

The concept of accessibility involves the ease with which young people can find answers to their sexual health questions and concerns. Though young people did not tend to use words like ‘accessibility’ in the interviews, it emerged as a theme when discussing where to go for more information or for help. The terms used most often to denote accessibility were “find out”, “get”, “go to”, “drop by”, “walk in”.

Accessibility, as a theme, might easily have been included in the previous chapter, as the accessibility of services is a factor that influences a young person’s ability to acquire sexual health information. However, as one of the purposes of this thesis is to question the assumptions that exist around young people being labelled as “hard to reach”, it seems more effective to discuss this concept as it relates to the provision of information. For accessibility could go either way. “Hard to reach” young people need access to services in order to get information, yet service providers likewise need access to “hard to reach” young people in order to provide that information. When we categorize

a young person as “hard to reach”, we are essentially saying that they are inaccessible to those who wish to reach them, rather than the other way around. Though the difference is subtle, it is nonetheless important, as it has implications regarding where the burden of responsibility lies.

### **7.1.1. Accessibility and the construct of “hard to reach”**

Accessibility is the single most significant factor in labelling a young person “hard to reach” and seems, in this usage, to refer to the ease with which adults can make contact with and educate young people regarding sexual health (among other things). Those who attend school regularly are deemed “accessible” as they are in a specific location for a specific amount of time each day, which makes them relatively easy to address. For those who do not attend school regularly the issue of access becomes complicated. Socially excluded young people are by no means a homogeneous group; there is no single, best way to reach them. Yet it may not be accurate to label them “hard to reach” in terms of their willingness to receive the information.

When I asked young people whom they thought was hardest to reach, they often appeared puzzled, as if they did not entirely understand the question. Rarely did they refer to themselves or their peers as falling into this category (the notable exceptions were two Muslim males who referred to Muslims in general as being “hard to reach” for religious reasons). Instead, most young people tended to think not in terms of ethnic or cultural groups, but only in terms of an individual’s openness to hearing and using sexual health information. Most seemed to think that those who are hardest to reach are simply those who cannot be bothered to use the information they may already have:

“Talk to them but they are not there to listen to you. . . . If someone doesn’t care you can’t make them care. The only thing they start caring is when they go through something themselves. They have to go through it themselves to realize. They catch something, then say, ‘Oh I’ve got to be careful’. Otherwise they won’t listen.” (YP19, F, 17, Portuguese-British)

“It’s silly to say that, I mean, look at Prince Harry. He’s got all the money in the world and he’s got access to information, top education you know and he’s still found in the gutter drunk out of his head. So I don’t think it’s got anything to do with your background . . . it depends on how responsible you are. You can’t generalize to say, ‘Oh all black people’ or ‘Somali people that can’t speak English’. No, I think it’s all around.” (YP10, F, 20, black-British Caribbean)

When asked why they think young people engage in high-risk sexual behaviours, the vast majority of young people were far less likely to say: “They don’t know how to protect themselves because they don’t have enough information” than to say, “They just don’t care”. Though a few did believe that sexual health education might go some way toward changing high-risk behaviours, most seemed to accept that young people “can’t be bothered”. Peer educators, too, seemed to believe that indifference, rather than ignorance, accounts for poor sexual health outcomes among young people.

As was discussed in Chapter Four, this apparent indifference might stem from several sources. Many “hard to reach” young people have competing needs that might seem more urgent, thus sexual health assumes a low priority. Many also do not perceive themselves as being particularly susceptible to unwanted outcomes, and will wait until they have a need for help before seeking out information.

It is also possible that “hard to reach” young people are being reached with sexual health information, they do have the knowledge, but their desired outcomes are simply not in accordance with those of the policymakers. This is especially relevant around the



issue of teenage pregnancy. Prof12, a 29-year-old black British outreach nurse who has had personal experience with teenage pregnancy, declared:

“I think a lot of people think it’s ignorant. I don’t think it is ignorant. If a girl misses her period and she has been in a sexual relationship the first thought is, ‘Am I pregnant’, so girls know, young people know if they don’t use contraception they get pregnant. So there must be another reason why girls are getting pregnant and why it is higher in some areas than others.” (Prof12)

Policies that stress education seem to believe that, if young people have the information to keep themselves safe, they will use that information. The end result should then be fewer sexually transmitted infections among young people and fewer teenage pregnancies. Yet this assumes the sexual health outcomes desired by young people are identical to those desired by the policymakers, and this might not be the case. Comments like those above tell a somewhat different story, and might call into question the whole construct of the category “hard to reach”, as it seems that, in some cases, a young person is given the label when they do not behave as adults think they should. In such a scenario, the young person is not necessarily “hard to reach” but rather hard to convince. It seems less a question of providing access to information than it is of convincing the young person to align her or his desired sexual health outcomes with those of the prevailing society.

### **7.1.2. Professionals’ views on who is “hard to reach”**

The professionals I interviewed were from diverse backgrounds, ethnicities, and levels of education, which seemed to be a factor in their opinions about who is “hard to reach”. Some believed that there are young people who are not only hard to reach but perhaps

completely unreachable, while others did not think any young people should be so classified. To explore this further, one of the areas I asked them about was whether they thought their demographic backgrounds (including socioeconomic status, gender and age) influenced their views that certain groups are harder to reach than others. Professionals who were from the same socioeconomic background as young people, had become teenage parents themselves, had lived or were living in deprived neighbourhoods, or were from ethnic or racial minorities, seemed to feel confident that they could reach out to the young people in their communities. They saw themselves as more acceptable figures in those settings than people who might have ‘only’ had the education and were now trying to put theories in place:

“[Y]ou need to look at the person as a whole not just to look at them and say oh she is pregnant . . . [Pregnancy] doesn’t happen in isolation; so many other things can affect it . . . I think being brought up in a deprived area in a sense made me appreciate the issues . . . I have been there.” (Prof12, F, 29, black-British outreach nurse)

Prof01, a 23-year-old black Somali Muslim female, indicated that having a similar religious and ethnic background as the young people she serves has helped her tremendously in understanding their unique situation. However, she went on to explain that: “As a negative aspect, my mother received some threatening calls from people from our community saying that your daughter is making our girls sluts!” She said that she had to move out her parents’ house and rent a separate place to protect her family from being harassed by angry members of their community.

Though coming from a similar background seems to play a part in making some professionals feel more confident in their capabilities, it by no means suggests that those from dissimilar backgrounds are any less effective in their work. In fact, those from

different background might themselves be less judgmental as they might be more curious about the lives of young people and therefore have a more open attitude towards their experiments with their sexuality.

Yet, generally speaking, it seemed that the more contact a professional had with young people, the less likely he or she was to believe that there is a category of young people who should be labelled as “hard to reach”. Several professionals even voiced the opinion that there is no such thing as a young person who is “hard to reach”, they (adults) simply had not discovered the best way to reach them.

“ . . . from my point of view no young person is hard to reach. They all can be reached if we just know how to reach out to them . . . ” (Prof03, M, black-African youth worker)

Prof03 went on to explain that the lack of resources is only part of the problem. Another aspect is the lack of collaboration among institutions (for example Pupil Referral Units, prisons, etc.). He made the point that many of the services that target “hard to reach” young people do not have a trained staff member who can provide ongoing sexual health information and support—instead they continue to rely on having outside experts come and deliver sessions, which might not be comprehensive enough to meet the needs of those who attend.

He explained that in his organisation he is able to access young people through the teen pregnancy education advisor, through Pupil Referral Units (P.R.U.s), and through Youth Offending Teams (Y.O.T.s), in addition to outreach work. Yet he thinks more could be done. He stressed the importance of not losing young people because of not knowing where to refer them, and explained that it is up to professionals to make the link between young people and the information and services they want. Prof13, a 32-

year-old black British youth worker, seemed to support this idea when she explained: “We don’t have all of it [all the information all young people want], but we direct them as where to get information. I had a girl who wanted it in Bengali; we have a telephone number of a directory to go there and for the information they need”.

An ideal situation might be one in which every professional who deals with young people is informed about the complementary services in their area. Prof 11, a 38-year-old senior nurse at a drop-in sexual clinic that targets young people, explained that this is the case in her place of work, yet throughout the interviews with other professionals it became apparent that most professionals did not have this kind of overall insight about the services available in their local area, which might then cause a young person to be lost in the process of referral. Overall it seemed that managers and high ranking officials were better informed about the other services available, perhaps because they liaise more with colleagues and attend more meetings with heads of other services. So, for example, Prof 11, who runs a health clinic, mentioned that she has done a lot of work with CLASH, London Action for Street Help, which has leaflets in languages other than English. Yet it seems there is not an efficient system in place to inform the people who work under them about these services, as none of the other professionals mentioned anything about CLASH when discussing the availability of leaflets in different languages.

Even in cases where the referral process among youth workers functions well, it still requires that the young person access the system in the first place. Although youth workers might be in the best position to reach out to young people in different settings, they are not necessarily the ones young people go to when they are seeking information or help. Among the young people who were interviewed in this research, many

mentioned that in a hypothetical situation, if they needed help with their sexual health, they would go first to a hospital. This was especially true of unaccompanied minors, asylum seekers and young people who did not have a clear immigration status and a place of abode. If this initial point of contact is not sensitive to their needs, if they're treated without compassion, the system cannot really fault young people for being "hard to reach". Many do reach out when they think they need help, but if the help they receive is not what they want, seems irrelevant to their needs, or is only offered begrudgingly, they are not likely to come back.

For most professionals, the "hardest to reach" young people included those who are not in education, employment, or training (NEET), as well as groups that object to sex education on religious or cultural grounds. Outreach work was frequently mentioned as an effective means of reaching the NEET group, however it was also seen as problematic for a variety of reasons. Because it can be dangerous, it is essential to work in teams. It also requires a certain level of training, which in turn requires resources. Prof04, a 36-year-old white Irish male who manages a youth programme, emphasized that having trained staff is a key element in running an efficient outreach service for vulnerable young people. He also mentioned some of the restrictions they face to achieve the ideal situation, including the time it takes to train the workers and the fact that he needs two workers for every post, as they can't be on their own.

In addition to training staff to do outreach work, retaining staff can also be Challenging. Although most of the professionals mentioned that they receive good managerial support, almost all of them, especially the youth outreach workers, also said

that they do not plan to stay at this job for long. It is a transitional phase for them. Many cited the lack of professional development available to them; there is no career ladder for youth workers, and there seem to be few career options that naturally evolve from this kind of work. This seems to be one of the reasons for the high rate of turnover among youth workers, which can have an adverse effect on the young people who bond with them.

Though outreach work is seen as effective, it seemed most professionals in this research expressed a preference for providing information in a more formal setting, such as a youth center or health bus, or having young people seek them out at clinics. Though the latter case puts the burden of accessing information on the young person, the providers still must ensure that young people know how to find their services. Prof03 explained that he prefers to have young people come to him for information, rather than doing outreach work, as they are more willing to listen and engage:

“ . . . if you manage to get young people together in an environment where they have sort of gone in together to listen and they know that’s what we have come here to do, its always easier to communicate . . . But usually if I just end up on a pitch and I’m like, “Young man, you know something? Did you know that HIV...?” they don’t want to hear it.” (Prof03)

To some extent, young people affirmed this observation, and a few expressed a dislike for being approached in the street. Yet others felt that it would be helpful to have the information given to them, perhaps in leaflet form, so that they could read later if they so chose.

A few professionals also expressed that they hope, through their work, to help young people feel confident to seek out information on their own:

“I think it’s alright not to know the answers, cause I think we’re encouraging people who ask questions . . . then we would look it up together with the young person . . . [and try] to engage in the process and actually teach them how they can go and find information.” (Prof04, white-British manager of a youth outreach programme)

It seems that at least part of the problem of accessibility includes educating young people on where to go for additional information, and helping bolster their confidence in doing their own research.

Overall, when I asked professionals whom they viewed as being “hard to reach” they were more likely to cite specific groups based on their individual experiences (e.g. Catholics, Bangladeshis, non-native English speakers) than they were to cite attributes of the individual, such as drug dependency or being a *teenage* parent, though these did come up. Prof03, among others, mentioned that he had a particularly hard time with Catholic schools, many of which would not let him provide SRE sessions to their students. And a few professionals mentioned that observant Muslim communities present a similarly difficult situation, though many did believe that they could provide information to these groups if given the chance. Establishing contact with religious leaders was mentioned as one possible method of increasing access to these particular “hard to reach” groups, though only Prof03 had done so at the time of the interviews:

“I was invited to deliver to a Muslim gathering and they separated the girls from the boys and I had to deliver to the boys first. Immediately after that one of their elders came in and gave the [Koran] perspective. Now, I think that that was okay. It also gives them an option. It also gives them, you know, a balance . . .”

Accessing these groups through the religious institution would have the added benefit of

offering a measure of reassurance to those interested in acquiring the information that it is not objectionable on religious grounds. It also could enable providers to get access to many young people who might not be found in more conventional places. For example, YP04 is an asylum seeker from Somalia who has lived “here and there” since he arrived in the UK two years ago and has no specific connection to any institution. However, he does attend mosque regularly. It is conceivable that he, and others, might be interested in a sexual health session similar to that provided by Prof03, above.

Most professionals were in agreement that young people with limited command of English could present a challenge, particularly when they come to the clinic with a family member who proposes to act as an interpreter. Three different professionals mentioned working with interpreters who were visibly uncomfortable with the material they were being asked to translate (Prof03, 10, 11). For this reason, providers prefer to use outside interpreters, or to have access to material in the languages most often spoken by their clientele. Several mentioned that in cases where language presents a problem they use videos, demonstrations, or other resources to get the message across. Once the young person is in the clinic, arrangements can be made to meet his or her needs. Yet getting them to the clinic, particularly for those who do not speak English, can be difficult.

### **7.1.3. Accessibility as it relates to availability**

Though it has already been established that young people prefer to talk to their trusted others about their sexual health concerns, when it comes to information or services that these people cannot provide they have a variety of sources to which they go. To some



extent, these are based on ethnic and cultural considerations. For example, five of the young people interviewed explained that they would prefer to go to their GP, rather than a clinic, if they needed help with their sexual health. Of these, four were black African Muslim males who had come to the UK seeking asylum; one was a black-Caribbean male who had grown up in the United States and had come to the UK two years previously. It seems possible that, given their life circumstances, their regular doctors may have been the only source they saw as readily available. There were also several young people who expressed preference for a different source of information—such as a nurse at a clinic or an outreach worker—but who went to their doctor out of convenience, or because they did not know anywhere specific to go.

A perceived scarcity of available resources also seemed to be the case for three white-British females, who mentioned that they would prefer to receive sexual health education in school. One explained that she wouldn't know where else to go for information.

Given that most “hard to reach” young people are not in school, the availability of other venues for providing sexual health information and resources takes on great importance. When I asked young people about their needs for information, most of them included a need to know *where to go* for help, including specific contact information:

“[At school] they gave me stuff about condoms and that, but nothing about where to actually go”. (YP12, F, 14, white-Irish)

“I don't think many people know that there is so many, well there is not many, but there is a few people out there that you can go and talk to . . . [but really] they don't know. No one knows.” (YP13, F, 15, white-British)

YP05, a 20-year-old black British Caribbean female who lived alone in a housing project, explained that her only source for sexual health information was her mother, and as her mother did not know about clinics, she did not know about them either.

Though some young people did know about the existence of sexual health clinics that are specifically designed for young people, relatively few had sought *information* from such a place. YP20 felt he did not need the information as he was a virgin, but he was confident that he could find such a place very easily if he wanted to:

“... there’s all these different clinics around yeah they do give free sex education and there are brochures . . . it’s quite easy to find one [if I want] . . .” (YPP20, M, 17, Turkish Muslim)

YP20 was not alone in being able to name vaguely what resources are out there but being unable to cite particular clinics. For example, YP01, a 20-year-old black Caribbean Muslim male, readily voiced that he would go to a clinic for help, but when I asked him if he knew how to find such a place answered that he did not. At the same time, most young people did appear confident that they could find such a place, *if they needed one*. YP17, who had been to a clinic with a friend, explained: “We just heard about it. I am not sure where I heard about them. I think you just hear about them.”

Relatively few of the young people reported preferring to receive information from a sexual health clinic, and those who did had been to a clinic for reasons other than acquiring general sexual health information. They had gone for birth control, for treatment of an STI, for a morning-after pill, or in support of a friend in need.

Professionals overall seemed aware of the problem of accessibility, in the sense of young people knowing where to go for help, and many seemed eager to discuss ways to make their programs known to a wider audience. They mentioned channelling more

resources into outreach work, as well as launching media campaigns such as posters and radio spots. Prof11, a 38-year-old white female who is a nurse in a drop-in clinic, explained:

“I think it is a bit of a problem is how people find out about the service. Because I think still hard to reach groups they are not going to look at the Internet, they are not going to their GPs to get leaflets, so I think that’s still a problem.”

Many professionals also seemed aware that young people will not go to a clinic unless they have a specific problem or concern, and for this reason they often will try to provide sexual health information at that time. They expressed a belief that this might be the most effective time to provide young people with information (along with the services they are requesting), as one might not get a second chance to access the young person in that anxious and captive mode again.

However, though professionals might like to make the most of it when a young person comes to the clinic, young people might not agree. For example, YP11, a 19-year-old black African Muslim male, explained:

“It’s easier to buy [condoms], yeah? . . . Once I went to a hospital to get condoms for my friend this lady started asking me all these question . . . I was ashamed.”

Many young people expressed that they were too shy or awkward to go to a sexual health clinic, and will only do so if they feel they have no choice. This young person told me that he has casual sex, so he might fall into the category of “at risk” young people and as such might be in need of further education about safer sex, but receiving it at a clinic might not be his preferred way. He was the young person who said he would go to his friends (referring to five other young men who lived with him in a council flat) if he

had any questions or concerns. He also mentioned that he would prefer it if the information could be posted to him at home instead of him having to go out to ask for it.

A number of individuals—young people, peer educators, and professionals alike—cited waiting time as a disincentive to attending a sexual health clinic:

“I think the other huge gap is not being able to see these people quickly and readily. If it takes time for somebody to get an appointment [they won’t do it], [so] they come to the open clinic but it’s already full. It can be very difficult. I think more drop-ins [referring to clinics] are needed.” (Prof11, manager of a sexual health clinic)

“[T]he times that they have you waiting, that needs changing because that’s what it is. People do not want to become faces standing around for time to see to little things like that, they just want to go there get the things and go like, they don’t want to be waiting around.” (YP21, M, 19, black-Caribbean)

“In fact, there is a lot of waiting and there is tension. It’s like, ‘If I was to go to a clinic for something simple why do I have to wait so long?’ So there is loads of people that don’t go there.” (PE06, F, 17, black African)

It seems that, in addition to young people needing specific information on where to go for help and information, it would also be helpful to make the staff in these clinics and other medical services more accessible in terms of their ability to see young people in a timely manner.

#### **7.1.4. Media**

Almost all young people have frequent contact with various forms of media in one way or another, from television and radio programs to magazines, newspapers, and the Internet. Professionals often discussed media in the context of its ability to get information out to young people, and most seemed to believe that young people would

listen. I wanted to explore this a bit further and so I asked young people if they ever actively sought sexual health information through media of any type.

The answers were quite positive, and they seemed to like the idea of receiving sexual health information via different forms of media, in part because it is anonymous and so their concerns about confidentiality are assuaged. The sources to which they reported they would go when seeking sexual health information were the Internet, teen magazines, and, occasionally, books. A few also mentioned listening to the radio, especially those who did not speak English well and had a channel to listen to in their own language. They generally responded positively to the idea of sexual health documentaries, as well as to information from various forms of new media such as CD-roms and text messages. Many also expressed that they would like a venue in which an adult professional could respond to their particular questions—such as an Internet chat room or a call-in radio programme.

Gender and age seemed to have a say when it came to a young person's choice of medium and the content of the messages. In general, it seemed the younger males, 14 to 16, and females of all ages said that they read magazines and books, while those 16 and over preferred to search the Internet and use their mobile phones. Internet was only accessible for most of the “hard to reach” group at libraries but most of them had mobile phones. It was interesting to note that several young people were relatively savvy regarding new media, and described using their mobile phones to access the Internet. I asked them what sort of sexual health information they look for and they generally giggled and said pornography images or videos. So it seems that even some of the most

excluded young people have some sort of connections with information, though it might not be the most useful information.

Although all would watch television, those under 16 said they would prefer to watch the programs that were designed for young people whereas those over 16 mentioned that they would watch other programs including DVDs. These all of course depended on the level of access they had to any of these media (including new media).

Overall it seems that young people want to see more programs addressing social, relationship and sexual skills:

“They don’t do it at the moment, they do it a bit but they don’t do it as much as they should, I think they should do more. I think it’s good because if you sit down and watch something, like the people who actually make the programme they make it interesting and make it so children wanna listen, it gonna like grab the attention of this group. Specially kids like today, they just like watching TV.” (PE01, F, 16, black-Caribbean)

Creating programming specifically for teenagers, with teenagers helping to design the material, was also mentioned by several “hard to reach” young people, as it would be more “on our level” (which I took to mean more accessible and relevant to them in terms of the language and content).

A few young women mentioned enjoying reading material specifically designed for teens, such as YP09, who liked to read teen magazines. When I asked her why they appealed to her she responded:

“Because most of them are health advisors are giving the advice . . . it’s a teenage magazine and you expect to trust them . . . we need all sort of these advise . . . I think they would give us the right information you know.” (YP09, F, 15, mixed race black/white)

She seemed to believe that teen magazines could be both accessible and reliable, as the articles would have to be factually correct in order to make it into print. I assumed paying for the magazines could be an issue for many, though no one mentioned it specifically.

Professionals, though aware of the tremendous potential in using all forms of media for sexual health education, seemed overall to be critical of the current content of media messages. (Prof13, F, 32, black-Caribbean youth worker)

“I don’t like it with my teenagers sometimes I am raged by the message that is given to them. It’s okay for you to beat your girl friend. It’s okay to have sex at the age of 12 behind your parents . . . So the message you are getting is that you can stay with your partner, you don’t need to get married, you know, you don’t need to have safe sex. And the consequences of what will happen is not shown . . .”

When I asked wheather media could be helpful, she said:

“I think definitely it will work, but first they need to work on the negative things they have at the moment . . . .”

Other professionals resonated this anger as well, especially when it came to the practice of sexualizing neutral messages in advertising.

Peer educators also seemed to be very aware of the impact of the media on young people, though, as has been discussed, they mostly did not include themselves in the category of “young people” when it came to the area of media impact. For example, PE02, an 18-year-old white British female, explained:

“. . . they publicize prostitution, they publicize young men sexually intercourse with older women, they publicize older men being with younger women and basically exposing young women’s bodies in front of magazines and stuff, and its not good for the young people’s mind.”

Yet despite the concern expressed by professionals and peer educators, several of the “hard to reach” young people I interviewed did seem to know the difference between the media and real life:

“When you look its all sex sex sex, even all the adverts, I don’t know if you looked there is this hair advert herbal essence or something but she goes like ahhhhhhhhhh, and my boyfriend was saying, ‘Why does everything you look at has to have some sort of hidden connotations to sex’? It’s ridiculous.” (YP10, F, 20, black-Caribbean)

“They show some [teenager] gets pregnant and decide to keep the baby and they don’t show nothing more, teenage girls who watch it gonna think, ‘Look how easy it is for her! It’s gonna be as easy for me so who cares if I get pregnant?’ or if they catch something they go to the clinic and they get sorted out right away. It’s not always like that and they show it in a nice way, in a glamorous way.” (YP19, F, 17, British Portuguese)

So although the mainstream media does not provide a realistic portrayal of the negative consequences that can result from sexual activity, it might also be the case that the extent of the damage they do is not as great as some might think. It seems possible that young people are not as impressionable as we often imagine them to be.

By and large the professionals expressed a great deal of interest in seeing the subject of sexual health become the focus of a national media campaign that might include posters, television and radio advertisements. Prof10, a black British manager of a leaving care team who is a great believer in the power of media, mentioned in particular putting posters in places frequented by young people. Ideally these would include both brief messages about sexual health as well as contact information for where to go for help:

“... there are certain shops that certain young people go into that nobody over 25 ever goes into because you’d look ridiculous in their clothing and the sort of the caps and the trousers that they’ve hanging round your ankles and that sort of style, you know. What’s wrong with



having a big poster up in a store saying something to do with the use of condoms or you know what makes that so much worse than a big poster saying smoking kills?” (Prof10)

She went on to express concern that the media focus in recent years has shifted from general sexual health—providing information and education about STI prevention—to a narrower focus that views teen sexuality in general, and teen pregnancy in particular, as problematic. She explained:

“I really think that, a few years ago in this country they had lots of adverts about AIDS and HIV and the rest of it on TV, primetime TV, you know nobody objected then, everybody soon realised it was important so why not take the same attitude towards the sexual health with young people?”

The idea of a media campaign was echoed by many professionals, as well as peer educators and even young people, who would like to see posters advertising contact information in particular. This might go some way toward solving the problem of knowing where to go for help.

Prof03 was one of the professionals in this research who had experience with producing media programs to address young people’s sexual health and relationship issues, and he continues to believe that media is one of the best resources to provide the information because it can educate young people as well as the adults who are in contact with these young people. As a person who led a media campaign in Africa, and is now in charge of a youth programme in a non-profit organisation that deals mostly with African young people, he believes that media campaigns are the best way to reach out to young people:

“I know that when I was working in Uganda, in Zanzibar, our radio had an impact on young people which is what I’ve noticed we don’t use here and that could be an amazing medium . . . . It does it well but it could be

better. I mean, I'll ask you this question. How many sexual health shows do you know? And then I'll ask you this question. How many kind of like, Jerry Springer shows do you know? On TV. Now. Every morning . . .”  
(Prof03)

He went on to give more detailed suggestions about the ways media might be used to reach out to young people who are not at school and therefore cannot receive the information in a systematic way:

“Think of a picture of Chlamydia, walking around or just saying ‘This could be you tomorrow’. That’s amazing. So poster campaigns in toilets, in raves or in clubs, that will make a difference. Little coasters, you know the ones you put glasses on, in pubs, in clubs. Those could make a difference. Radio. Every funky, fly, extremely cool D.J. saying listen gentleman or ladies safe sex, did you know? . . . If we did radio shows that went as national as other radio shows on sexual health, that would make an impact. If we had magazines that were just as good as say, *Cosmo*, for young people with five pages on sexual health. That would make a difference. . . A lot of people who are not in school, they listen to radio, they watch TV. If they can read, they will read magazines. They drive around, see posters or they walk around, see posters. They go clubbing, see these things. I’m sure that will make a difference.”

The concept of using mass media as an outreach service has also been discussed elsewhere (see Nasserzadeh, 2008). Peer educators and even some young people also mentioned the idea of using shocking photographs of sexually transmitted infections as a media resource.

“. . . they have to make it disgusting like this ad on cigarette . . . that the oil comes out . . . its really disgusting. I think this will work, like, to show these pictures of STIs on big billboards on the street.” (PE04, M, 17, black-Caribbean)

Remembering what we know from the previous chapter—that young people often do not seek sexual health information because they do not feel the risk is significant enough to

warrant immediate attention—this might go some way towards convincing them of both the importance of sexual health and also their own susceptibility.

The overall sense from “hard to reach” young people, peer educators, and professionals is that media is a great, unexplored resource when it comes to making sexual health information accessible, and a lot more could be done. As was mentioned previously, “hard to reach” young people are not a homogeneous group, and different types of media might appeal to various subgroups within this category:

“Books are best for lots of factual information. Videos and DVDs are used to show such things as sexual techniques, positions, etc. The website is used to have a major database of information, FAQs and the like which visitors can access 24/7. Mobiles are used for short ‘sex tips’ – 160 characters and spaces of bite-sized bits of useful information.” (Prof05, producer of sexuality education materials for adults)

Having a wide variety of such resources available to young people would ensure that they could access the information via whichever medium is most comfortable for them.

When I asked young people and peer educators what other media might be useful to them they mentioned text messages and posters, magazine articles, and educational videos or CD ROMs, among several other things. However one needs to remember that, for both genders and all ages, their first choice was to talk to someone. So while media might go some way towards getting the information out there, and would most likely improve accessibility for “hard to reach” young people who do not receive SRE in a systemic way, it should not be considered a substitute for one-on-one sessions with a trained counsellor or healthcare professional.

## **7.2. Helpfulness**

The theme of helpfulness emerged in relation to the way young people perceived the sexual health information they had received or would like to receive, particularly in terms of its relevance in the context of their lives. The terms most commonly used to indicate helpfulness included ‘useful’, ‘good to know’, ‘help’ and ‘helpful’.

As has been described elsewhere in this research, young people will not seek sexual health information unless they think it is relevant to their situation and they believe they need it. After they have passed this stage, they want to know what information is available to them and where they can access it. It seems that having information on the potential risks of sexual activity, and on the resources available to them, is crucial. They want to know the specifics of sexually transmitted infections, how to prevent them and how to recognise if they have one; they want to know about contraception and conception (in terms of the biology of reproduction); and they want contact information on where to go for help. This seems to be the information they find most “helpful”.

### **7.2.1.Helpfulness as it relates to outcome**

It is easy to assume that the information one actually uses would be considered the most helpful, therefore helpfulness could be assessed in terms of outcomes. For professionals, this seems to be the case; they hope that the information they provide will be put to use. Yet, in this research, the providers and the recipients sometimes had different outcomes in mind, which could account for the difference between what young people perceived as helpful and what was designed and delivered to them by professionals.

Professionals want young people to use sexual health information to lower their

rates of teenage pregnancy and STIs. Though everyone was interested in avoiding an STI, not all the young people interviewed agreed that teen pregnancy was a negative health outcome. Of the 13 young women I interviewed, seven expressed no interest in becoming pregnant and explained that they would probably terminate an unintended pregnancy. One of these had a 17-year-old sister with a child. Of the remaining six, one had become pregnant intentionally, though she later changed her mind and terminated the pregnancy (YP13); two expressed an active interest in becoming pregnant sometime soon (YP14; YP17); two expressed that although they had no plans for getting pregnant, if they were to become pregnant by accident they would consider becoming parents if their circumstances allowed it (YP15, YP12); and one explained that though she would not like to be a teen parent, as her own parents had been, she could see how it might appeal to others (YP09) as it would give you “someone to love”. The young men I interviewed were not as verbal on the subject of teen pregnancy, and seem far less interested in teenage parenthood, though a few said that they might consider having a baby if they thought they could provide for it. And one, YP21, a 19-year-old black British male, had become a father at the age of 15 and was expecting his second child at the time of the interview.

Young people considering parenthood seem to want practical information that will help them get through the situation (which many believe is normative). One young woman who was seriously considering becoming pregnant described the circumstances in which it would be acceptable to have a child:

“... if they want it and you can cope with it then it’s all right. If your family can’t deal with it then it’s hard because you have to have an abortion or have the baby to be put on the foster care or whatever else. But if your parents can cope with it and be supportive you can plans for [the]

future and go to school, college, then having a baby is all right.” (YP14, F, 14, white-British, Christian)

When I asked her what sort of information might she find helpful, she said: “I want the truth. I want them to help me to make a better decision, not to change it, you know?” In this scenario, a healthcare provider who focused only on prevention would not be seen as helpful.

None of the professionals encouraged teenage parenthood, though most acknowledged that those who were pregnant (or already parents) needed resources to help them make the best decisions for themselves and their children. One youth worker invites teen parents to come in and talk about their experiences with other young people:

“Well, not every teen mum has a very exciting story to tell and the ones I work with some will say it was terrible and some will say it was great . . . But what we’re trying to say to young people is if you are making the decision make it because you believe you can do it, make it because you believe that if I do have a child now I will be responsible for that child . . . . If you know you can’t, don’t do it, forget it, leave it ‘til later.” (Prof03)

In this way he seems to be addressing the concerns of people like YP14, helping her to make a better decision rather than trying to make the decision for her.

Thinking of outcomes as an indicator of helpfulness is also problematic when one considers the existing gap between having information and making use of it—a gap recognised by most of the young people interviewed. Having the information does not necessarily make young people delay sexual activity or change their sexual behaviour, as there could be other factors that motivate them to engage in a sexual relationship at an age or in a manner considered “risky” by professionals. Yet they perceive the information as helpful whether or not they actually use it.

Peer educators for the most part seemed to understand this gap from both

perspectives:

“You can't be sure that anyone will use the information you give them, you just have to be confident that you're delivering it right and you give them the right information and that's as much as you can do. You can't make them putting on a condom, you can't make them not share drugs, all you can do is ask them not to.” (PE05, M, 17, black-British Caribbean)

“There is lack of knowledge but you got to remember that it's ignorance as well . . . You can talk but if I am not listening, I am not gonna learn nothing. You have to be in a 50 /50 relationship. You have to be a teacher, youth worker, whoever, but at the same time listen as well. There is no point talking but not listening to them.” (PE04, M, 17, black Caribbean)

PE04 brings up the important point that part of providing SRE includes listening to the young person's questions and concerns—without listening and asking questions of young people it is impossible to know what might be helpful to them.

### **7.2.2.Helpfulness and one-on-one SRE sessions**

Most professionals seemed to agree that the best possible method of providing sexual health information is one-on-one or in small groups, which seems in keeping with the method preferred by young people. By talking with the young person, learning what he or she already knows and wants to know more about, one is able to customize the material to suit the needs of that person. One-on-one sessions also enable the provider to ascertain the learning style of the young person and understand how his or her life situation might dictate what sort of information might be most relevant. Information can then be provided in the format that will be most helpful, whether through visual material, in written text, or in an interactive style such as a CD-ROM. Young people might know what they like or dislike but might not be clear about what will work for them in terms

of retaining information. For example, YP22, an 18 year old black African Muslim who lives alone in a council flat, explains that he uses the Internet to seek sexual health information but *cannot* say that he prefers this method. Though he has read about STIs he has forgotten much of what he read. Yet he could remember the STIs he read about that also included photographs. In a one-on-one or small group session with a professional he could be given customised information, accompanied by photographs or other visual aids, to help him retain the information.

Customizing information to the individual has the added advantage of enabling the educator to provide all the appropriate information, both what the young person identifies as a need and what the professional believes is necessary. So, for example, if a young person believes he doesn't need to know about any forms of birth control beyond condoms, the professional might suggest he learn about other types of contraception as well, just so he has the knowledge. As has been discussed, young people sometimes do not have enough of a knowledge base to be aware of areas of ignorance. A trained professional can evaluate their current understanding of sexual health and provide additional relevant information. Of course, in this scenario the professional runs the risk of providing information that is unwelcome, but that risk could be balanced out by the value of the information provided.

### **7.2.3. Wants vs needs: the importance of choice**

One finding that emerged throughout the interviews relates to the subtle difference between “wanting” and “needing” information. Young people tend to describe their sexual health information needs in terms of what they “want to know” rather than what



they “need to know”, a phrase more often used by professionals and other adults. Yet when adults discuss a young person’s “needs”, they are usually describing what *they* think young people need, which might not necessarily be in accordance with what young people express or see as their needs. At least this was the case in this research.

It seems possible that young people could see acquiring sexual health information as a matter of choice rather than a necessity, as if the information itself was not viewed as being vital. As was discussed earlier, this could be due to their competing needs, as well as their perceptions of their own susceptibility. Yet professionals and peer educators seem to believe strongly that young people definitely need this information in order to avoid negative sexual health outcomes in the future.

Along the same lines, when young people were discussing the type of person with whom they *would* like to talk about sexual health, they would mostly say, “I prefer”, which supports the idea that they see themselves as having a choice; they would choose this person among others. Yet when they had an actual sexual health concern they were more likely to say: “I need”, which could mean they have been in a situation where they felt a need for a reliable source of help or information.

Among the young people interviewed for this research, most seemed to have a relatively good idea of where they would go for help with a sexual health problem, such as clinics, a hospital, or their GPs. Yet when they were asked where they would go to seek information specifically, not in a time of crisis but just for the purpose of educating themselves, some sounded puzzled. This was most evident in the different responses I received to the questions, “Where would you go if you had a sexual health question?” and “Where would you go if you had a sexual health concern?” For questions, young people

go to their trusted others; for concerns they go to a healthcare professional. It does not seem to occur to them to go to a professional for information, only for help.

#### **7.2.4.Right place, right time**

An individual's perception of what is helpful can change over time— what seemed helpful at one time might not be seen as helpful at a different time or under different circumstances. Prior to the onset of sexual activity a young person might not feel she needs to know specific details about birth control options; later, that information could become more important to her:

“[When my mother told me about sex] oh, I was embarrassed I didn't want to hear no more of it and wanted to leave it, and later on I got more serious to find more information and how it works.” (PE11, F, 17, black Caribbean)

To some extent, then, the helpfulness of information will depend upon the circumstances in which the information is given, and the young person's receptivity at that moment. If resources are available to young people at the “right place, right time”, meaning when they think they need them, there seems to be a greater likelihood that the information will reach them and will be considered helpful and relevant. The opposite may also be true: if you approach young people when they are otherwise busy and try to talk to them about sexual health, they may not want to listen to you.

Even when the young person is most receptive it does not guarantee that they will take in all the information they receive, but at least they are targeted. For YP20, a 20 year old black British Caribbean female, the “right time” was when she went to a clinic with a friend who suspected she might be pregnant. YP20 saw some leaflets on the table

and picked them up. For others it might be something different: when they go to their doctors to discuss birth control options, at the beginning of a new relationship, or when they suspect they might have an STI and are seeking help. If young people tend to go to the medical/health care settings in time of perceived need for help, it seems only logical to make sure there is an accessible educational resource available to them at that time, when they are most likely to be keenly interested in the material.

More or less all the professionals in this research (and other research) suggested the increase of youth-specific services and clinics. They tended to stress the importance of having personnel trained to be sensitive to young people's issues and skilled in communicating with them effectively. Such services would also protect young people's confidentiality, which seems in accordance with what young people want for themselves. These clinics could be an excellent source for providing opportunistic SRE, as the very fact of the young person's appearance in the clinic indicates his or her interest in sexual health information.

This is not to say that more formal, structured SRE sessions are not helpful; on the contrary, they can be very helpful if the information provided is seen as being relevant to the young person's life, and if the manner of delivery is engaging and non-threatening. Yet most of the SRE sessions experienced by the young people in this research were described as being "not helpful" or "not useful" for a variety of reasons, the primary one being the quantity of information provided, which will be discussed in more detail below.

It also emerged that the person of the instructor had an impact on whether or not the information provided was seen as relevant or helpful, particularly in the case of

formal SRE sessions. Though most young people did not express an age preference when it came to the medical professionals who provided sexual health services, such as nurses and doctors, they did express a preference when it came to receiving sexual health information:

“Like I said before, that's all about how you relate to a person. If he is, like, say, like a 45 year old man and he looks like professor type and have glasses on, his suit, nobody is going to listen to him, they're just [frame their chewing gum being snapped at him] you know what I mean? Where if you had a young 25 year old woman who's coming in and she talks about her own experiences . . . then it would be more informative cause you'd get more response and attention.” (YP10, F, 19, black-British Caribbean)

So it would seem that in addition to being in the right place at the right time, it is also important to having the right person provide the information.

Many young people also expressed a preference for having a more lively and interactive style of SRE, rather than sitting still for a lecture. The professionals who worked directly with young people seemed to agree that the way a session is conducted will have an impact on whether it is perceived as helpful and relevant.

“ . . . you have to really try and engage them. So the lecture style is good but probably is not the best way to go about it. When we do evaluation of the sessions, one of things they always say is that when we do the hand on stuff, they get to use the condom demonstrator, that's the thing they'll remember the most, rather than listening.” (Prof14, M, white-Irish, curriculum developer)

Prof14 went on to explain that there is some difficulty in finding an educator who is confident about the material and comfortable conducting the sessions:

“They really pick up on the people who are not very skilled or confident. They say, ‘She doesn't know what she is talking about’. They do want people who know the subject. So that's a big gap. And I don't see that to change much in near the future. Because we haven't

got so many teachers and people who can do a range of just SRE. I think that might not change a lot.”

Though the material itself is important, it seems that the method of delivery and the person who conducts the session also have a tremendous impact on the perceived helpfulness of the information provided.

### **7.3. Quantity and quality of the sexual health information**

The quantity and quality of sexual health information provided is closely related to the perceived helpfulness. In this section we will focus on quantity and quality in terms of the content of the information provided, the amount of information provided, and the forces that impact the amount of time that can be dedicated to sexual health education and instruction, both within schools and also in alternative setting. It should also be mentioned that to some extent it is impossible to distinguish between quantity and quality when it comes to the provision of sexual health information, as the quality of the sessions seem to be directly linked to the quantity of information provided and amount of time allowed for the session.

#### **7.3.1. Age as it relates to quantity of information**

Most of the young people interviewed expressed varying levels of dissatisfaction with the formal SRE sessions provided in schools, and examining the reasons behind this dissatisfaction yielded a rich source of material regarding what they *did* want to hear about in an SRE session. The areas most often cited as inadequate were the amount of information provided, which was seen as being insufficient, and the method of delivery.

Most learned something about the physiology of human reproduction, and a few learned about HIV/AIDS and the importance of using condoms, but none were given specific information about STIs, or detailed information about different types of birth control, which were listed as the areas about which they most wanted and needed to learn.

It is important to keep in mind that many of the research participants dropped out of school at a relatively young age, thus the SRE sessions they did receive were most likely geared towards younger students, which may in part be responsible for the scarcity of relevant information. Several seemed to believe that this information was withheld because they were seen by the educators as being “too young” to need it, as they were for the most part below the age of legal consent (16) when they received SRE in school.

One youth worker informed me that the content of the sexual health sessions he provides changes when a young person turns 16:

“It would be more graphic for anyone who is over 16 so it would be more vivid. We would give more description to sex, and information. For anyone under 16 we would probably be highlighting risk taking behaviour, so we would be talking about sexual behaviour, drugs, alcohol in one topic and we’ll be saying, ‘Don’t do this because it’s risky’ . . . . After 16 we are talking about . . . negotiating for safer sex, because obviously they are going to start making decisions to have sex. We are talking about condom use which we haven’t mentioned before they become 16.” (Prof03, M, 25, black-African youth worker)

Young people said they want objective explanations of the practicalities of sex and its consequences. However, based on Prof03’s words, the sexual health information he provides for under-16s is not detailed and does not include birth control or condom use. So it seems that a gap exists between the information young people want to hear and the information some professionals provide. Among the professionals interviewed for this

research, Prof03 stood out as having an outstanding grasp of the realities of young people's lives, and his words in general were the closest to what young people said, yet he did not seem to be aware of this gap.

Withholding information for those under the age of consent seems similar to the abstinence approach, in that adults appear not to want to accept the realities of young people's lives (Kirby, 2002a). Instead of providing the necessary information they turn a blind eye to the entire issue by encouraging young people not to get involved in sex in any way, which seems unrealistic. Prof 03 is in a position to decide over providing or withholding the information to young people. He believes that providing sexual health information to under 16s will encourage their risk-taking behaviours while the literature indicates quite the opposite (for example see Kirby, 2002a; 2002b). Prof 03 reports that some of the under-16s he works with have active sexual lives. Therefore, one could argue that they will miss out on useful information that might prevent them from engaging in unwanted, coerced, or risky sexual behaviour. From a rights-based perspective it does not seem possible to justify depriving young people of information that might help them to protect themselves (United Nations General Assembly, 2002; Davey, 2005).

This withholding of information is likely influenced by policies involving the provision of sexual health information and services for those under and over the legal age of consent. The professionals who worked in health-care settings seemed overall to be more comfortable dealing with under-16s, possibly because of the protocol provided by the Gillick competency, which assesses whether or not a young person has reached a level of maturity sufficient to enable them to understand and benefit from the

information and services they receive. Almost all the outreach nurses I interviewed said they would provide information based on the young person's situation, provided they satisfy the Gillick competency. Even if a young person is 14, the fact that she has an STI and came to the clinic to be treated means that she should be given the information and is most likely able to handle it.

Youth workers seemed to be less aware of this form of assessment and seemed less comfortable providing a detailed level of education to under-16s. For some, lack of experience seems to be a factor. Many youth workers only hold their positions for brief periods of time, and the rate of turnover is high. One needs more than a few months of experience to make a judgment call regarding whether or not to provide information to someone who has not reached the legal age of consent. Fear of parental disapproval also has an influence on the decision to withhold information—they do not want to provide information that parents might not want their children to hear. When I raised my concerns with Prof03, he explained that he and his colleagues will provide answers to any under-16s who ask questions, but they would rather not give out too much information proactively to them. This is the experience for Prof03 as a youth worker.

Though many young people may wait to initiate sexual activity until they are 16 or older, those in the “hard to reach” category seem to begin at an earlier age. One young woman who became sexually active when she was 12 (a year after the death of her mother) explained:

“Teachers just assume that kids who are younger aren't be gonna having sex but they are gonna be having sex and to be honest most teenagers who, for example I go to referral schools, or have problems at home, I think the majority of them would be having sex. Because they just do, I don't know, that's just what they wanna do. Cause like when my mum was around I don't think I would have sex but when



my mum died I felt like I wanted to do it. I do what I feel like . . .”  
(YP15, F, 15, white-British)

It seems significant that, even to this 15 year old, there exists a link between having a hard time in one’s personal life and the onset of sexual experience. Socially excluded young people, who might get less emotional support in the time of need, might be more vulnerable because of their life circumstances. This could make the information even more valuable to them. Many of those I interviewed were sexually active well before they reached the legal age of consent, and believed they would have benefited from more explicit and comprehensive information.

Peer educators were in agreement with their counterparts in the “hard to reach” group in this regard, and seemed to believe that providing information to younger students in general would be beneficial:

“I think it should start earlier as well, and it should be more detailed not leave out information because you think they’re too young to handle it because a lot of things, a lot of people, a lot of kids are maturing earlier as well so their feelings also are going to come out earlier as well and they’ll want to experience stuff earlier as well. So I think the earlier you educate them the better they will be in those situations they might come in to.” (PE08, M, 15, black-African)

Though most young people and peer educators seemed to agree that SRE should be provided at an earlier age, it is important to mention that there were a few individuals in all three groups—“hard to reach” young people, peer educators and professionals—who expressed the concern that this information might encourage young people to experiment with sex earlier than they might have had they not received this information. The idea is that too much information, at too early an age, could be a “bad” influence on their decision-making process. Yet it could also be argued that the decision to begin sexual

activity is far more complicated than that, and includes a wide variety of factors for each individual.

It also seems possible that accurate sexual health information could have the opposite effect, as would seem to be the case in some countries with more proactive sexual health education and, not coincidentally, lower levels of teenage pregnancy and STIs (such as Holland, Germany and Finland; UNICEF, 2008). Two young expressed the belief that more information might actually be a disincentive to engaging in sexual activity:

“I think they could give us a bit more [information]. About everything really. I don't know, just, like, everything, just to cover sexual stuff, like what can cause pregnancy, disease. I think that they tell us but they are not telling us enough not to make us, like, not do it. They need to tell us a bit more about it.” (YP14, F, 14, white-British)

“... the more knowledge you have about this the less you would, you would try to avoid having STIs and diseases. But if you don't know about it then you really wouldn't think twice before you do certain stuff. So, yeah, I think the more knowledge you have about sexual health the less likely you will contract a disease.” (PE08, M, 15, black-African)

For both of these young people, more information on the specific risks of engaging in any sexual activity could provide the motivation needed to practise safe, or safer, sex. It seems possible that this could be true for other young people as well.

An added benefit to providing formal SRE at a younger age is that having no previous knowledge just might make young people more curious and more open to receiving sexual health information, whereas if they are older they are more likely to have shaped their knowledge base and their attitudes from miscellaneous sources, not all

of them reliable. Professionals are then faced with not only providing information but also correcting misinformation (also see The Cornerstone Consulting Group, 2001).

What's more, they have the difficult task of trying to convince the young person that he or she is actually in need of the information. Having been exposed to sexualized media, and having received information (or misinformation) from their peers, they feel they already have all the information they need even though they have not been fully and structurally educated in this regard (Carrera, et al. 2000).

Were professionals to provide a greater quantity of information at an earlier age, it could go some way towards ensuring that this type of formal education is available to all young people, even those who might drop out at a later date and become "hard to reach".

### **7.3.2. Need for formal assessment of programs**

One reason why the formal SRE sessions in schools might be inadequate has to do with the lack of feedback and evaluation informing the work of those who develop the curriculum. Prof14, a curriculum developer for school-based SRE, explained that needs assessment is not done routinely in mainstream schools. Instead, he relies on the teachers to explain what they think the students most need to learn:

"... we have to see what the school curriculum wants. And so the teachers say, 'Okay we have some teachers to do the contraception, we don't need any help with that but our teachers don't know about STIs. Can you come and do that?' So that's how it works. But what we have to try to do for next year is to go in and say, 'Okay this is what you think we should offer and this is what we tend to offer. But how about asking the young people as well?'"

It seems significant that he does not experience the same problem in PRUs, where he is able to ask the students themselves what they most want to hear about. However, even in the PRUs they do not have a formal assessment of the programmes they offer.

Throughout this research I found myself surprised by the lack of formal programme assessments and rigorous evaluations in virtually every setting in which I conducted interviews. Whether health busses or leaving care teams, youth-specific sexual health clinics or outreach programs, none of the professionals received regular, structured feedback from the young people whom they were trying to help regarding the usefulness and value of the services they offered. Of course, those I interviewed tended to work in locations that were specifically designed to appeal to “hard to reach” young people who, by their very definition, are difficult to access for follow-up. Youth-specific clinics, for example, are designed in part to provide the very anonymity that makes this type of robust evaluation impossible, leaving the professionals with no way of monitoring the effects of the training they offer.

In many field-based outreach settings professionals develop their own curricula based on the structure that the National Strategy for HIV and Sexual Health provides. For example, Prof04, who manages a programme that targets young men under the age of 18 who are at risk of sexual exploitation, explained that his team has developed its own syllabus:

“... we’ve come up with our own syllabus I think, around delivering sessions, which is we do developing over the years and new workers bring their own skills and knowledge to that. And we have tools that we can pull out for young people, so we have lots of resources here and develop our own around this, around how we bring up sexual health with young people in a way which is safe and firm and informative.”

One can easily see the value of this approach, especially as throughout this research it became apparent that each young person might express a variety of needs and desires for information depending on their current circumstances and levels of experience.

It seems that the closer the professional was to the grass-roots level of education, the more likely they were to be providing information that was seen as relevant by their target group. Those who work directly with young people, and in more intimate settings, generally have more flexibility than higher-level authorities like Prof14, above, who writes curriculum that will be used widely in many different school-based settings and might be more restricted by regulations and policies. Because these curricula *cannot* be tailored to individuals or even to specific groups, they run the risk of being too vague and general to satisfy the information needs of those who are on the receiving end. This seemed to be the case for those young people I interviewed who had received at least some SRE before leaving school but found it inadequate.

In 1995 Oakley and colleagues had conducted a robust systematic review on the reports from sexual health education interventions for young people and assessed the methodological quality of those evaluations (Oakley, et al. 1995). They reviewed 270 papers and concluded that the design of evaluations in sexual health intervention needs to be improved so that reliable evidence of the effectiveness of different approaches to promoting young people's sexual health may be generated (Oakley, et al. 1995). This study has not been duplicated again to give an understanding of the solidity of papers up to 2009. Though developing one's own curriculum based on the needs of the target audience does seem to be an effective solution to the problem of knowing what kind of information is most relevant, it still doesn't satisfy the need for an evidence-based

approach to the provision of sexual health information. Even though following up with young people is difficult, if not impossible, and even though robust evaluation can seem an unattainable goal given the circumstances in which many of these services occur, an evidence-based approach to the provision of sexual health information is still preferable and merits further research.

### **7.3.3. Quantity and quality of information as they relate to considerations of time**

Most of the professionals who provided structured SRE sessions, both within traditional schools and also at other venues, mentioned that time, or a lack of time, was a significant factor in how they conducted their sessions. It affected not only the amount of material they covered, but also the instructional methods they used and their ability, or lack thereof, to get feedback from the participants on the effectiveness of the sessions.

One youth worker disclosed that not having the chance to develop a rapport with young people could make sessions difficult. She explained that young people might be offended by the information because of their faith beliefs; they also might have other underlying fears that translate into anger towards the provider if they are approached with information that makes them uncomfortable.

“Sometimes time is short, sometimes it’s not easy to do that because people can get embarrassed cause it shows that they have got an STI and they can get aggressive. If you are not too sure about the group you are working with, like the groups you only meet once, you can’t do this with them because you need to get to know them first.”  
(Prof13, F, black-British Muslim youth worker)

She suggests to ‘do it right’ you need time to bond with young people and then provide them with the information. Yet in the context of outreach work this is often impossible.

Most of the professionals mentioned time restrictions as having an impact on the services they provide in one way or another. Prof03, a youth worker, explained that you should not say to a young person, “Use a condom” one time and then walk away; you have to say it over and over. This implies that a single session might not be enough to get the message across. Prof09, who manages a health bus, explained that though she will give condoms out to those who ask, she prefers to spend some time with them to ensure that they know how to use condoms effectively, as well as to respond to any other questions or concerns they might have. Prof12, an outreach nurse, explained that raising young people’s self esteem would have a positive impact on their sexual health, but that this end cannot be achieved in only one or two sessions. Rather, professionals need time to develop close relationships with each young person in order to bring about such a change.

For those who provide SRE sessions in schools and other institutions, the amount of time allotted for each session was often seen as inadequate. Prof14, the curriculum developer mentioned above, explained that the methods young people seem to respond to best include demonstrations, role playing, and open-ended conversations about a variety of subjects. He went on to explain that many young people need help with “developing their skills in terms of being assertive and being able to actually say what they want in a relationship”, particularly around negotiating condom use. However, all of this takes time, often much more time than has been allotted for sexual health education:

“[Sexual health education is] about building up a relationship over time, and in the mainstream school that's something that really doesn't happen. It 's usually a one-off visit or might be two or three visits over a few weeks. They can have their value but I think it's much more valuable if someone would to go there over half a term or a whole term . . . in order to build up the trusting relationship. So it is a failing in the

model that schools have this amount of time for sex and relationship.”  
(Prof14)

This was corroborated by several young people who had received some SRE in school yet also thought it should be given more importance in the curriculum in terms of the amount of time devoted to it:

“Like they would talk about, like, protection and stuff but then after that they will move on to talk about something like about what sort of things you should eat and stuff like that” (YP09, F, 15, mixed race black/white)

“... I really can't remember, in PSE they cover variety of topics you know and sex would come up every so often but it wasn't a big thing, you know? I think they should make it more part of the curriculum.”  
(YP10, F, 19, black British Caribbean) female

PE09, a 16 year old black British male, expanded on this idea when he explained that inefficacy in delivering sexual health messages can jeopardize their intent. He explained that it is not enough to simply give the information in lecture format; you also need to get young people to talk about and deal with their thoughts and feelings around the subject. As an example, he explained that no matter how much one promotes condom use, if a young person feels it will reduce his pleasure he will not use it.

“That is why you have to teach them more about the condoms, like take different types and open it in front of them and show them how to use it and show them how to wear them and you show them there is different types of condoms there is sensitive ones, there's thin ones, there's strong ones, so when you say, 'Use a condom', they immediately think 'But you'll lose feeling'. As soon as you get them on the right side of their ears they'll listen ... hopefully that should change their minds.” (PE09)

Providing information without allowing for this type of interaction is, to his thinking, an inefficient way of conducting SRE. Telling a young person to use a condom without



demonstrating to ensure that he or she knows how to use one is not likely to increase the chances of a condom being used at all. Yet when time is limited, as it seems to be for the professionals included in this research, this level of instruction remains unlikely.

Given that the amount of time dedicated to sexual health education in schools is seen as inadequate by both the providers and the recipients, it seems logical that extending the length of each session, and providing a greater number of sessions, would be a good first step towards improving sexual health awareness more generally.

#### **7.4. Conclusion**

The discussion around the concept of who is seen as “hard to reach” came to life around the issue of accessibility. It seems significant that young people rarely considered the category of “hard to reach” as applying to specific religious or cultural groups, and certainly not to groups that might include themselves. Professionals and peer educators, on the other hand, seemed to have very definite ideas about who is seen as “hard to reach”, though overall it appeared that those who are in close contact with young people, such as outreach workers and youth workers, tended to have more faith that everyone is reachable if one can only figure out how to reach them. Young people, peer educators and professionals all stressed the importance of making sexual health services more widely known so that young people might have an easier time of knowing exactly where to go for help or more information, and various forms of media were cited as meriting further exploration in terms of their ability to provide sexual health information and contacts.

By and large, the helpfulness of the information provided was judged by young people in terms of its relevance to their lives, rather than in terms of the outcomes it promoted, which was more the case for professionals. Young people seem to want as much information as possible, though they might not always use it to “improve” their sexual health outcomes, as those outcomes might be different than the ones intended by the providers (particularly in the case of *teenage* pregnancy). If “accessibility” reflects whether or not young people see the information as being within their reach, “helpfulness” seems to reflect whether or not young people see the information as being relevant to their lives and therefore something of which they are in need.

Finally, examining the quantity and quality of the information provided in various settings made clear the reality that most “hard to reach” young people do not receive adequate formal, structured, and thorough information regarding their sexual health. This is due in part to the fact that many of them drop out of school before such information is provided, but it also seems to have something to do with the intentional withholding of information based on the legal age of consent. The amount of time given to sexual health information sessions, both within the school setting and also in other venues, was seen by all three groups as a hindering element to the provision of information.

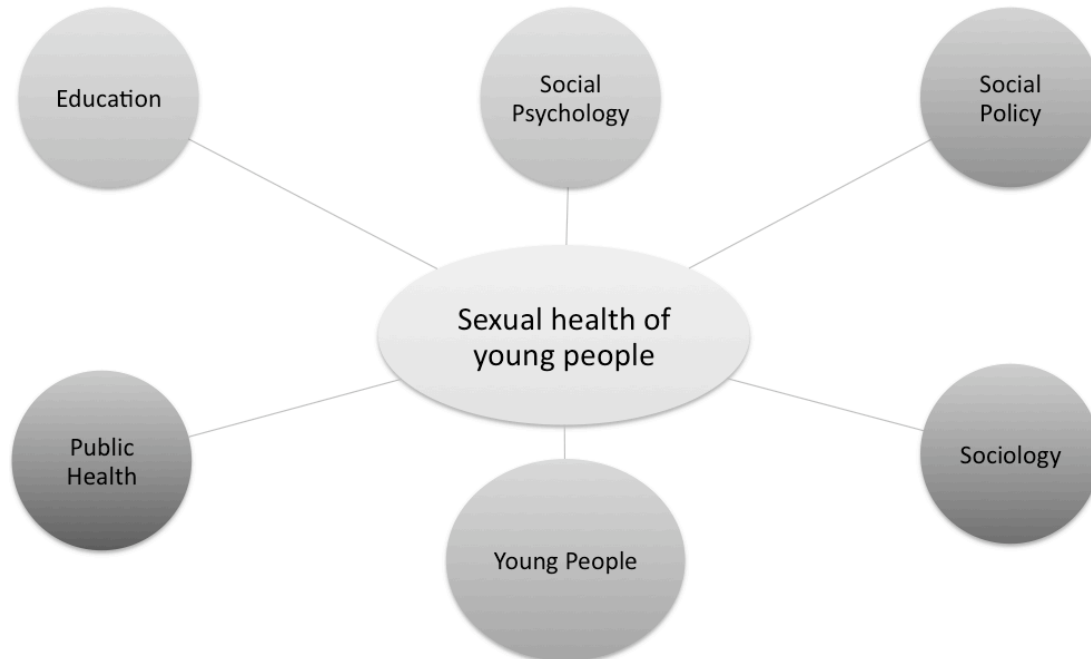
Analysing the complex context of provider-recipient interactions, as well as the factors that are involved in defining each groups attitudes and actions, further emphasises the importance of taking a multi-layered approach to the sexual health information needs of “hard to reach” young people. One must first examine the contexts of young people’s lives in order to understand what their needs are before planning a strategy to address as

many layers as possible. It is not difficult to see why social exclusion has become such a big discourse within the Government , as it seems that lack of access to sexual health information and services is only a part of the bigger picture of a lack of general access to social capital and resources.

## Chapter 8: Discussion and recommendations

### ***8.1. Different perceptions of the same phenomenon***

In the end, this research was a remarkable example of the role perception plays in understanding social phenomena. Different disciplines view the “problem” of the sexual health of vulnerable young people differently and will make interpretations of the phenomenon based on their epistemology and particular focus. For example, while from a public health point of view the high rate of STI is an area of more concern, teenage parenthood might be a more serious issue from a social policy point of view because of its link to social exclusion and the isolation of the young parent. The construct of the problem is described in the model below.



There is also a growing body of literature to show that young people might not agree with any of these interpretations. For example, in the research we did with teenage

mothers in Haringey (Hoggart, *et al.*, 2006) we found that most of the pregnancies were intended and wanted by these young people. Not only did they not see themselves as being socially excluded, they actually reported feeling empowered financially (via benefits or housing), socially (via mothers' groups or status as a parent) and even emotionally. Therefore, while something could be seen as a problem from the adults' point of view, such as researchers and politicians who help shape policy, the young people who are the focus of such policies and strategies might not share this opinion.

In this research, differences in perception were especially apparent when I compared the interview transcripts of the three groups; young people, peer educators, and professionals. At times all three groups seemed to be in agreement, for example they all felt that existing clinics should be advertised better and easier to locate. At other times they were more divergent, as when discussing providing sexual health information to young people under the age of sixteen. At times the professionals even disagreed amongst themselves.

The main findings from this research indicate that the whole concept of "hard to reach" is itself problematic. First, the young people to whom it is applied share very little in common beyond their status as not being in mainstream education, in employment or training. Second, the perception of a young person as "hard to reach" is embedded in a multi-complex context that seems to depend less upon the individual's accessibility than it does upon who is doing the 'reaching out', for what purpose, and with what end in mind. Young people and policy makers are not always in agreement about what constitutes a "negative" sexual health outcome, particularly when it comes to teenage parenthood, which is more subjective than other outcomes. Finally, the concept of "hard

to reach” assumes a causal relationship between “negative” sexual health outcomes and lack of sexual health information that may not exist.

Some of these findings present a challenge to current policy and practice approaches, as any approach that focuses solely on providing information in order to change sexual health outcomes is, in this view, unlikely to succeed. The findings suggest that a rights-based approach to sexual health education, rather than an outcomes-based approach, is probably preferable – certainly from the young person’s perspective.

## **8.2. Recommendations**

Providing sexual health information to socially excluded young people is a complicated task that requires participation on many levels, from the young people themselves to the outreach workers in the streets; from the curriculum designers to Government agencies who develop policies geared toward helping this group of marginalised young people. In this section I will set forth some recommendations, based on this study, for action in the future.

## **8.3. Development and training**

Overall there appears to be a need to share these findings to ensure that policy makers and service providers are aware of young peoples’ views. A good place to begin would be to develop a model based on all possible input from everyone who plays a part in informing and developing sexual health policies, as well as the provision of information from teachers, nurses, and other health care providers to social workers, key workers, and youth outreach workers. Each of these individuals and groups needs a clear

understanding about *why providing sexual health information matters* and *how they should go about it*, which is in accordance with the rights-based approach to healthcare (Nasserzadeh, 2009b). They also need to understand (or question) what the different agencies are actually working towards. For example, if a community worker thinks that her work will contribute to reducing the number of sexual relationships that occur outside marriage, but community members do not support or agree with this agenda, she would be unlikely to be using her knowledge and efforts effectively.

There also appears to be the need for a feedback mechanism between the groups to whom evaluation information is provided and the groups who are funding, designing, delivering and evaluating the services provided. This would also require better input from young people. In recent years, steps have been taken in this direction, as more and more sexual health policy is shaped by grassroots workers. For example, the director of the Teenage Pregnancy Independent Advisory Group attended “Sex and Relationship Education Conference (SRE 2009)” in Birmingham and reported being fascinated by the data presented from the range of different sectors and communities represented. At this time, conferences such as the biannual SRE conferences and the annual Brooks Advisory Centre conference, which allow people from less academic backgrounds to present their experiences, have limited space. Having more of such opportunities could go some way towards bridging the gap between professionals, providers and young people that this study has highlighted.

Along these same lines, this research has indicated that information is not always disseminated well *within* organisations. This could be remedied, at least in part, by creating a comprehensive database, accessible to all professionals working with young

people, with a complete list of local and regional services that are available. The proposal for such an initiative has already been submitted to the “SRE 2009” conference organizers by the International Platform for Sexuality and Relationship Education (IPSRE) (Ohlrichs *et al.*, 2007).

It would also be helpful if sexual health educators were trained according to standardised guidelines, in order to ensure some level of consistency in terms of the information being provided. There are currently two international guidelines for training sexual health educators, both of which could be adapted to become culturally appropriate for the needs in different communities, cities and boroughs. One is the *UNESCO’s International Guidelines on Sexuality Education* (2009) and the other, in which I was involved, is *The World Association for Sexual Health Guideline for Sexuality Education and Promotion* (2009). Both offer structure and suggestions about what should be included in the lesson plans for different groups, as well as information on how they could be delivered and evaluated.

#### **8.4. Development of effective outcome measurement methods**

It would also be useful, although challenging, to develop rigorous outcome measurement tools to assess the effectiveness of the sexual health education programmes currently in place. The classic evaluation method of pre-post intervention, plus additional follow-ups, may be difficult to implement with hard to reach young people as they are not easily accessible and, even if they are, there is no clear way to establish whether or not behaviour change was due only to the intervention (Kirby and Coyle, 1997). Measuring behaviour change based on the provision of information alone could be inaccurate as



there are many factors that influence human behaviour (Hubley, 2000; Kirby *et al.*, 1994; WHO, 1996) or lack of it (the behaviour) (Gatawa 1995, UNAIDS 1997a); no one lives in a controlled environment and learning is shaped by many individual factors (Rotter, 1954; Rotter, 1989). Nonetheless, one possibility going forward could include a joint effort by all providers and services in a given locality to establish a database for vulnerable young people and track behaviour changes over time. Although challenging this may be feasible.

Another possibility might be to involve researchers in developing information-based interventions that could be designed in such a way that their effectiveness could be measured accurately at the end. An example of such a project that was informed by a multidisciplinary steering group is the one in which I was involved (Voluntary Action Camden, Somali and Bangladeshi Peer Educators Project). We worked with peer educators to develop educational material, which we then took into the field. We were able to revise it based on the feedback they provided. (This project is ongoing; details may be viewed at: [http://www.vac.org.uk/projects/Peer\\_Education\\_Project.htm](http://www.vac.org.uk/projects/Peer_Education_Project.htm)).

Ultimately the usefulness of any evaluation method is based, at least in part, on how the whole process of sexual health information delivery is perceived. If it is seen as a valuable experience for a given target group, then robust project plans that includes a form of outcome evaluation that involves that group. The development of validated evaluation tools for certain groups might be a starting point in this process.

### **8.5. Raising levels of awareness**

Throughout this research professionals expressed concern that young people did not know about the services available to them, and this was confirmed in the interviews with the young people themselves; few of who could name a specific clinic or outreach programme in their area. Professionals had suggestions for improving their visibility, including posters, radio spots, advertising in magazines and newspapers, and handing out leaflets in the street. Young people also mentioned providing contact information during school-based Sex and Relationship Education (SRE) sessions.

Professionals also suggested raising levels of awareness in more general ways about the potential risks of any sexual activity, which could help address the discrepancy between what young people think they need to know, which may be very little, and what professionals *think* young people need to know. Raising levels of awareness could in turn increase perceptions about the susceptibility to certain risks. Since the start of this research, Channel 4 launched a range of programmes addressing sex-related issues, including an HIV storyline in the soap Hollyoaks, a youth-inspired series Lifeproof, the multimedia [www.slabovia.tv](http://www.slabovia.tv) website, and the pre-watershed series The Sex Education Show.

Because the young people in this study had low levels of perceived need for sexual health information, in part because of low levels of perceived risk to negative health outcomes, more of them may simply need to be encouraged to seek prevention in the form of better information rather than access to any treatment services.

## **8.6. Developing a wide variety of materials and resources**

Hard to reach young people are not a homogeneous group, and the variety of ways in which they expressed their preferences for receiving sexual health information reflects this level of diversity. Preferences were highly idiosyncratic, and demonstrated a need for a wide variety of materials and resources including leaflets, books, individualised sessions in a walk-in clinic, receiving information from General Practitioners, small-group sessions, mobile units such as the Health Bus, interactive CD-ROMs, interactive websites, call-in radio programmes, and receiving text messages on their mobile phones. Whatever resources are developed must also be available in the young person's native language and in an appropriate format.

### *8.6.1. Appraising the context in which the services are provided*

There is body of literature about what encourages or discourages young people who visit sexual health clinics, such as the attitude of the staff, from the receptionist to the health care provider (e.g. Hayter, 2005; Lewis, 2004; Department of Health 2000, p2; Brook, 1998). However, there is less information about creative ways to approach young people who are socially excluded and do not belong to majority groups or institutions.

The young people in this research reported that *trusting the source of sexual health information was more important to them than its accuracy*. With this in mind, several professionals suggested utilising existing community structures to reach out to vulnerable young people, so that those they trust might be more involved in the provision of information. Those who work among immigrant populations or in communities where religious observance is an organizing principle of the group, for instance, could work in conjunction with community and religious leaders to devise appropriate methods for

providing information. In addition, parents (as well as other adults with whom young people might be close) could also be provided with both reliable information and a set of basic skills in talking about sexual health with young people. There are examples of success with such models from different countries with similar beliefs about the role of the family in providing sexual health information (e.g. Poureslami, *et al.*, 2007).

Sometimes the barriers to acquiring information are intrapersonal, such as simply having too many competing needs to take the time to go to a clinic. In other cases barriers can be interpersonal, such as when a young person's trust has been jeopardised by the way they have been treated by the system in the past. In light of these findings it is possible to suggest that interpersonal barriers could be rectified through robust training of health care staff and providers. The starting point may be to begin with what can be controlled, managed and changed in terms of information and its provision. Afterwards it may be possible to look at what could be done on a larger scale to include young people in society and encourage them to address their personal perceptions about sexual health, and eventually to start to challenge them.

## Chapter 9: Conclusion

The findings from this study indicate that the views of the providers might be different than the views of young people who are at the receiving end of sexual health information and services. Also the task of improving sexual health outcomes in vulnerable young people is more complicated than simply providing accurate sexual health information.

Though information is important, it is only one small piece of the picture.

It is also crucial to understand what young people want from sexual health information.

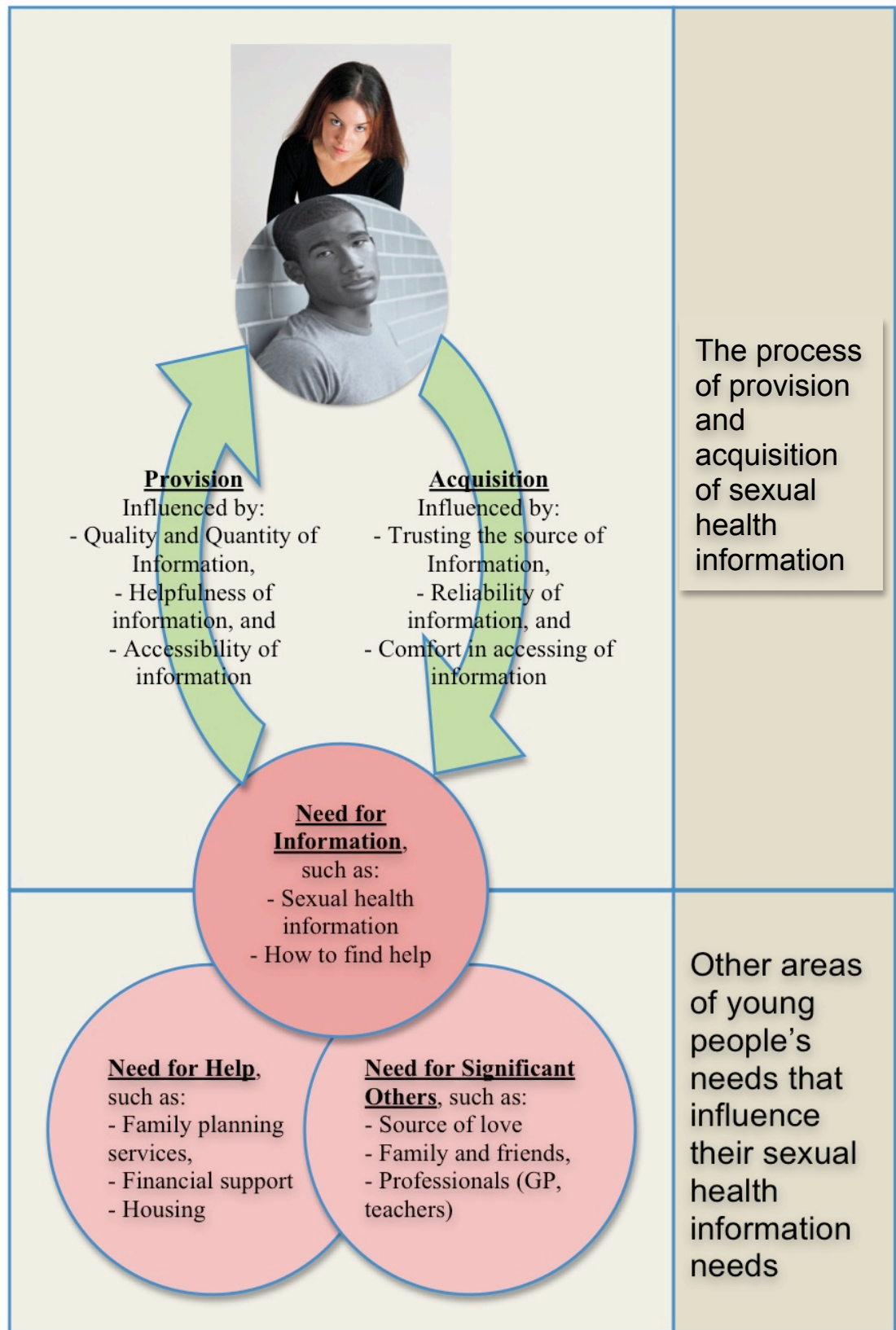
What is more, the very fact of their exclusion implies that they have needs in many areas of their lives, including help with finances, housing, career counselling and education.

They also have needs that are important but less practical (such as self-esteem), possibly making them harder to address. All young people need informed and capable adults in their lives both to help them with their immediate needs and to act as role models; they need emotional support as well as financial support and they need to feel that they

belong. As expressed in the UNICEF report (2001, p. 27) they need:

‘ . . . a stake in the future, a sense of hope, and an expectation of inclusion in their society.’

All of these needs impact on vulnerable young peoples’ perceptions of need for sexual health information, as described in the model below.



Given the complexity of needs, attempting to improve the sexual health outcomes of vulnerable young people by providing them only with better information or access to services seems too narrow a focus, particularly since these outcomes seem to be more the result of their social exclusion than their lack of information. Greater success might be possible if we were to try to improve the quality of their lives in a more general way by addressing social exclusion, rather than focusing only on improving their sexual health outcomes.

On a personal level, I feel privileged to have been able to undertake this research, and believe it has provided access to the voices of young people who might not otherwise have been heard. Starting out I made every effort not to have preconceived ideas of how the research would go or what I might uncover. Nonetheless, I often found myself surprised by what I heard, particularly during the interviews with young people. They have needs in so many areas of their lives, yet despite these circumstances, or perhaps because of them, many exhibited a level of maturity that was remarkable. They not only seemed to know who they were, they also had ideas about how they are seen by others in the society: namely as a “*problem*”. They also seemed eager to have their voices heard, and to have some of their needs addressed. I believe if we (the adult community) make more efforts to enhance the social wellbeing and inclusion of young people, there is more likelihood that they will start to care about their health and will be able to see a purpose for their lives. Most would agree that this is a purpose to fight for. I will end these few hundred pages with a shocking quote from a 16-year- old young woman:

“They say no body cares about me so I might as well enjoy my life...this boy in our building wanted to jump under a bus...he says this way neighbours will remember me...”.



### Appendix 1. Demographic Form (young people and peer educators)

Age	Ethnicity
Religion	How important is religion to them in their everyday life?  1(V).....2.....3.....4.....5 (N).....
Type of school (single sex, Catholic, Moslem, etc.)	Schooling (still attending?)
What level completed (what age they left?)	How many sessions of sex education did he/she receive when was at school?
Occupation	Current relationship status: (Married single, separated? With partner? etc)
Area/with whom they live? (Squatting, no fixed abode,, etc)	First part of their postcode
Parental occupational status	Where their parents come from originally?
English proficiency  1(WCom).....2.....3.....4.....5(NW Com).....	Their native language (and the language they speak at home)
Residential status (citizen, asylum seeker, etc.)	_____ _____

If they would like me to send them a copy of interview transcript before entering it to the final draft, fill the box above with their e-mail or mailing address.

## **Appendix 2.**

### **(A) Interview cues and probing questions for “hard to reach” Young People and Peer Educators**

#### **Main cues:**

- **Life context**
- **Perceived needs**
- **Perceived barriers**
- **Cues to action**

#### **Life context (in combination with demographic form)**

Tell me a bit about yourself

- Where do you live?
- How do you like the neighbourhood?
- Where do you usually hang out?
- How did you end up out of school?
- How do you spend your time these days? (if not in extended school)

#### **Early Experiences, Needs and Preferences for Sexual Health Information**

- When was the first time you received any form of sexual health messages?
- How did you receive it? (Radio, TV, friend, parents, etc)
- What did you feel about it? (Did you feel you needed it?, soon?, late?, wrong person delivered it?) Why?
- If you did not like the way you received it, how would you have liked the information to be given?
- Why?
- Do you still prefer the above mentioned way or have your preferences changed?
- Why do you think your preferences have changed? (if changed)

#### **Current Needs and Preferences for Sexual Health Information**

- In your opinion what should a good/effective sexual health message be like?
- Who is the best person to deliver it?
- How should they be delivered? (poster, text messages, Internet, etc.)
- Where do you want to receive or see them? (home, street billboards, magazines, etc)
- What are the things about sexuality that you think you need to know more about?
- How would you prefer to receive the information needed in this regard?
- Why is that?
- If I was a sexual health expert, what questions would you like to ask me?
- How would you expect the information to be given to you? (being explained to you? Skill based training? Being given a book/leaflet? etc.)
- Why do you think this way is better?
- Do you think all other young people think the same?

- Was there a time when both/all of you were puzzled over an issue? If yes, what did you do?

### **Understanding perceived needs for sexual health information?**

- Are you satisfied with the knowledge you have about your sexual health?
- What might help you to avoid being affected with sexual health diseases
- Do you think young people's sexual health problems are because of lack of knowledge? If yes, what do you think could be done about that? If no, what do you think are the reasons then for them to take risks that lead them towards having sexual health problems?
- Do you think you have enough knowledge about these matters?
- If no, what do you think you should do to gain this knowledge?
- What is wrong with the current information on sexual health available for young people?

### **Experience of services**

- How would you know if you were affected with an STI?
- How would you know if you were pregnant? [females only]
- What would you do if you find out that you have STI?
- What would you do if you find out that you are pregnant? [females only]
- Have you ever been in a sexual health clinic before?
- When? Why was that? What was your experience?
- Did they provide you with any form of information (leaflet, advice, skill sessions, etc.)?
- If yes, how did you find that? Helpful, readable, cover the things you wanted, appropriate, detailed enough, were you able to use it?
- How would you like to change them?
- What is the reason for you to come here today? (if attending somewhere to seek help or information)
- Why did you prefer to come here rather than going somewhere else, (eg. SHC)
- What kind of help are you hoping the clinic/ health bus can give you? ( if appropriate)
- Do you think there should be other information available together with sexual health information? (eg. Alcohol problem prevention, etc.)

### **Other sources of information / influence**

- What do you think about the media's coverage of sexual health information (e.g. the television programs like: As If, Holly oaks, internet, etc.)
- What should the role of the media be?
- In your opinion, who should be writing this information for young people?
- Do you talk about sexual issues with some one? Who? Why him/her?
- If you want to make an important decision, whom would you consult with? (probe: to behave in a certain way, have sex, not to have sex, to smoke, etc)
- Why?
- Do you feel pressurised by any one? Who? Why? In what aspects?

- Whom do you feel closest to?

### **Access to information / judging the information**

- For young people like yourself, how can you get this information?
- Was there a time when you wanted to find out sexual health information?
- Please tell me about the experience?
- Where did you go to get the information?
- Which source you think is the most reliable for getting sexual health information now?
- How do you judge if a source of information is reliable?

### **Understanding the context and attitudes of socially-excluded young people**

- What do you think about under-aged pregnancies? (Probing around; advantages, disadvantages, any benefits, etc.)
- Do you think having sexual health knowledge can prevent you from STDs/unwanted pregnancies?
- Do you have any plans for 5 years from now?
- Which group of young people you think are harder to reach?
- Do you smoke? If yes, how many cigarettes a day? Is this regularly every day or some days only? (probe, if pattern is not regular: why it is not regular? How many do you smoke per week then?)
- Do you drink alcohol? If yes, when was the last time you had any alcohol? On the occasion, what did you drink? (Whisky? Beer, wine, etc.) Was that usual for a night out (as appropriate)? If no, how much do you usually drink? How often do you drink? In a typical week? In a month?

## **Appendix 2.**

### **(B) Additional interview cues for peer educators**

- How did you come to be a peer educator?
- Do you think it has had any affects on you?
- How do you evaluate your need for sexual health information before and after being trained as a peer educator?
- Who do you think is the most difficult group of young people to reach for sexual health information?
- Why do you think that is?

## **Appendix 2.**

### **(C) Professionals' Interview cues and probing questions.**

#### **Background information**

- Gender
- Age
- Job title
- Responsibilities- particularly in relation to sex education (adolescents)
- Background, growing up

- How long have you been in this job
- What brought you to this job
- Which groups have you worked with

**What do inform the design and content of information they deliver? (personal and professional factors)**

- What is the curricula you cover?
- Who designed them? On what basis?
- How are they different for different groups of young people?
- What are the main topics you usually cover when you educating young people?
- Do you see any gaps between the topics you cover and what young people want to know (based on your experience?) , in what way?
- How you get to evaluate your work?
- How young people have a say in this?
- In general which topic of sexual health should be emphasized for young people (particularly harder to reach ones) in your opinion and based on your expertise? Why?
- What are your suggested methods in delivering sexual health messages? Why?
- Is this different for different groups?
- Why do you think that is?

**Method of delivery**

- Do you use different methods for providing information about different topics? What are they?
- Can young people choose how to be educated?
- Do you think they are effective? Yes. No; how can they made to be more effective?
- Any intervening factors that you could think of?
- Are these different for different groups of young people? Example?

**Challenging situations**

- Which groups has been the most challenging one for you (access, delivery, etc.)
- Did you have a difficult situation to deal with? No. yes; what was it? How did you handle it? How could be made easier?
- Who do you see as the hardest to reach adolescents?
- Why do you think they are hard to reach?
- Are they really hard to reach?
- Does it affect the way they perceive their needs?
- How are they different from their peers?
- How could we include them?

**Sensitivity to culture, language, religion**

- How do you deal with language barriers/difficulties?

- Have encountered a case with language difficulty? No. yes, what did you do? How did you handle the case?
- How would you deal with cultural differences?
- Have you had any difficulties dealing with clients from different cultural background? No. yes, what was the problem? How did you handle it?
- Are your services different for different age/gender/culture? (e.g. under and over 16, or boys and girls or Muslims, etc.)

### **Professionalism versus personal experiences**

- Have you ever encountered a demand/question from young people for which you did not know the answer? No. yes; what was that? How did you handle it?
- Do you receive adequate support (professional development, mentally)?
- Is there any particular topic that you think you need more support for it?
- How your personal experiences contributed to your work? Any conflicts?

### **Factors influencing young people's perception and preferences regarding their needs**

- Do you see any gaps between the services you offer to young people (hard to reach one, particularly) and what their need is? No. yes; what are they? How we can fill them?
- How do you evaluate hard to reach young people's competitive needs?
- How do you see their needs for sexual health information in the context of their lives?

### **Environmental/social factors- other influential factors on shaping young people's perception and cognition.**

- What do you think about other information resources available to young people? E.g. Media?
- How do you evaluate the usage of different kinds of media in delivering sexual health messages? E.g. Computer games. Have you ever used them? How was the experience?
- Do you see any conflicts between what you offer to young people and what they pick up from other resources? Media, family, peers, etc.

### **Other**

- Is there anything you want to raise or add?

### Appendix 3. Information Sheet

Title of the Research  
**Sexual health messages “understanding young people’s needs and preferences for sexual health information”**

My name is Sara Nasserzadeh. I am a student and doing my research at Middlesex University.

**I really need your help to do my research, but It is okay if you don’t want to take part.**

**If you decided to take part it is okay to drop out any time you want to, I won’t ask you why!**

**What will happen?**

- I will interview you
- It would be totally confidential, I would not even ask your name
- The interview should take about 30 to 45 minutes.
- I have been working with young people for 5 years now and I am sure you will find me easy to talk to

**What will I ask you?**

- I will ask you about the sexual health messages/information you need and how you prefer to receive them

**What should you do to take part:**

- I am at the clinic right now, just tick one of the boxes bellow and return it to the receptionist or the health advisor you will visit to be directed to my room.
- Or feel free to contact me if you have any questions regarding the research or want to introduce a friend to take part later: [s.nasserzadeh@mdx.ac.uk](mailto:s.nasserzadeh@mdx.ac.uk) or 07974399262

I would like to take part in this research

I would not like to take part in this research

I would like to take part in this research but not now my number/ e-mail is:

.....

## Appendix 4. Consent Form

Consent Form: One to One Interview  
(young people and peer educators)

Title of the Research “ <b>understanding young people’s needs and preferences for sexual health information</b> ”
---

Centre Name:

Interview Number:

- 1- I confirm that I have read and understand the information sheet dated.... For the above mentioned study and have had the opportunity to ask questions. ☐
- 2- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
- 3- I agree that my participation may be tape-recorded. ☐
- 4- I agree to take part in the above study. ☐

Name:

Date:

Signature:

Name of person taking consent (if different from researcher):

Date:

Signature:

Researcher:

Date:

Signature:

One copy for participant; one copy for researcher



**Appendix VI. Demographic information of young people**

ID	Role	Locality and neighbourhood	Parental status	Religion	Age	Gender	Ethnicity	Education	Employment	Relationship	Immigration status	Language proficiency
YP01	Young Person	Kentish Town, job training centre, Kentish in Town, N4	Single parent	Muslim	20	M	Black Caribbean	Finish high school at USA	non/Camden Job Training Centre	None	British passport	5
YP02	Young Person	Kentish Town, job training centre, Kentish in Town, N4	both parent	Muslim	17	M	Black African (Somalian)	finished year 11 in the UK	non/Camden Job Training Centre	GF/ a non muslim gil, not for marriage	came with cousin, 6 years ago, citizen now	5
YO03	Young Person	Kentish Town, job training centre, Kentish in Town, N1	both parent	Muslim	19	M	Asian (Bangladeshi)	in Bangladesh mostly, did GCSE's in UK did not pass	non/Camden Job Training Centre	GF/ Muslim, Bangladeshi, family knows about her. 1.5 years with her. Don't really mind. My mind is not into it yet, while other people you know they are but my mind is not to this things yet.	came to Uk 8 years ago, citizen now	4
YP04	Young Person	Kentish Town, job training centre, Kentish in Town, N17	family and live here and there sometimes	Muslim	18	M	Black African (Somalian)	never been in school	non/Camden Job Training Centre	none, I prefer Muslim girls for marriage but for now for relationship whom I feel close to.	came two years ago, did not allow recording	3
YP05	Young Person	SHINE, housing project, Focus E15, E15	single mother, a while with step dad then again single mother household	Christian	20	F	Carabian-Black-British	1 month ran away from home and school then back when was 14 (sexually abused). Because my step father abused me and I couldn't actually, I thought school was useless. I ran away, I stayed with my cousin; I came here, I went to Birmingham, I went to different places.	college student	BF 4-5 years now	citizen	5
YP06	Young Person	in a bus from Enfield, N17	single father	None	17	F	White -British	starts college in two months	none	None	citizen	5
YP07	Young Person	BETS	mother and father both	Muslim	16	F	Iranian	left school at 10- back to school (extended school)	student	BF 3 years	came to the uK 12 years ago, citizen	5, speaks Farsi at home
YP08	Young Person	Brook Euston	parents seperated	None	18	F	Iranian/brought up in Sweden	college student	international student	yes but not serious	International student	3, speaks Farsi and Swedish
YP09	Young Person	BETS- South Kenton	seperated	none	15	F	mixed race: black-white	left school at 14, in extended school now	student	BF for 4 years	citizen	5,
YP10	Young Person	council flat, E3	single mother	Christian	19	F	Black British /Caribian	left uniat 19, law	solicitor rep	yBF 1.5 moths	citizen	5
YP11	Young Person	Houseing project E15	seperated	Muslim	19	M	Somali came to the UK 11 years ago	got GCSE	college-part-time	GF for 7 months	asylum seekr, now citizen	4-5 speaks Solami at home
YP12	Young Person	with mum and little brother NW10	seperated	Christian	14	F	White-Irish	completed year 9	BETS (been here for 2 months now)	none	citizen	5
YP13	Young Person	NW9	seperated	Christian	15	F	White-British	left last year/private school/was at home until 2 months ago	BETS (been here for 2 months now)	BF for 11 months	citizen	5
YP14	Young Person	HA8	both parents	Christian	14	F	White-British	left last year	BETS (been here for 2 months now)	BF for 7 months	citizen	5
YP15	Young Person	NW9	mother died when she was 11, lives with dad	Christian/Jewish	15	F	White-British	completed year 10 at BETS	BETS	no	citizen	5
YP16	Young Person	NW6	mother and step dad	Catholic	14	M	English/Irish	left after year 10	BETS	no	citizen	5

YP17 (never completed the interview)	Young Person	Queensbury	doen's know her mum, doesn't meet her father that often	christian	14	F	mixed race: Carrabian-white	left after year 8	BETS		citizen	5
YP18	Young Person	NW9	both parents	Christian	14	F	Black Carrabian	left in year 10	BETS	no	citizen	5
YP19	Young Person	N17	both parents	christian	17	F	mixed race: portugis and English	completed A levels	college	no	citizen	5
YP20-UM	Young Person	Haringey	live alone in a student hostel	Muslim	20	M	Turkish	studying to get to college	N/A-wants to be a security guard	no	citizen	5
YP21-UM	Young Person	Haringey	live alone, sometime with mother	Christian	19	M	Black-British	N/A		Yes	citizen	5
YP22-UM	Young Person	Atlantic Lodge	share a flat with other boys	Muslim	18	M	black-Eritrea	N/A		no	asylem seeker	3
YP23-UM	Young Person	Atlas Housing, Haringey	Housing project, share a flat with other boys	Christian	16	M	Black- Angola	N/A		no	asylem seeker	2

**Appendix 6. Frequency of the most cited keywords and phrases in “hard to reach” young peoples’ interviews.**

Word/Phrase	Frequency	Number of young people mentioned the word/phrase
I_DON'T_KNOW	191	20
SEX	186	21
INFORMATION	137	19
SCHOOL	104	21
NEED*	99	19
FRIEND*	93	16
MOM	90	17
CLINIC	70	17
DOCTOR	64	17
PREGNANT	63	15
CONDOM	63	15
GP*	58	11
TEACHER	50	14
HELP	48	13
BABY	41	13
RIGHT	39	15
SEXUAL	38	13
PILL*	37	11
CHILD*	36	14
SMOKE*	35	12
BOYFRIEND*	34	10
HOME*	31	13
TRUST*	28	11
INTERNET	27	15
SEXUAL HEALTH	27	13
CONTRACEPTION	27	10
PREGNANCY	26	12
TV	26	12
DAD	22	10
I_NEED	22	9
MONEY	21	12
LEAFLET	21	11
SOCIAL_WORKER	21	4
COUPLE	20	8
ADVICE*	19	10
DESIEASE	18	11
SISTER*	18	8
TEENAGE*	18	7
KNOWLWDGE	17	10
SUPPORT*	17	7

BROTHER*	17	7
INFECTION*	17	7
DRUG*	16	10
STREET*	15	8
LOVE*	15	7
COUNTRY	15	6
MOTHER*	14	9
LIFE	12	11
LEFT	12	11
FUTURE	12	9
RISK*	12	8
TALK_TO_MY	12	7
NURSE*	12	6
CHLAMYDIA	12	4
HELPFUL	11	7
MUSIC	11	7
SCARE*	10	7
LANGUAGE*	10	7
VIDEO	10	7
HOSPITAL	10	6
ABORTION	10	6
TELL_ME	10	6
SEXUALITY	10	7
GIRLFRIEND*	10	5
MAGAZINE	10	5
HOUSING	10	4
ALCOHOL	9	7
FIRST_TIME	9	7
FAMILY_PLANNING	9	4
KILL*	9	3
I_BELIEVE	9	1
ADVISOR	7	6
PROFESSIONAL	7	4
I_PREDER	6	5
DANGER*	6	4
SINGLE	6	4
ALONE	6	3
POOR	6	3
AIDS	6	3
GAY	6	3
I_DON'T_UNDERSTAND	5	5
VIRGIN	5	4
RELIGION	5	4
COMMUNITY	5	4

FATHER*	5	4
ASK_MY	5	4
BOOK	5	3
TELL_MY	5	3
WEBSITE	5	2
SPEAK_TO_ME	4	3
INJECTION	4	3
DISGUISING	4	2
HIV	4	2
CONCERN*	4	2
RADIO	3	3
FOSTER*	3	2
YOUTH_WORKER*	3	2
RELIGIOUS	3	1
RACE	2	2
PLEASURE*	2	2
MEANING*	2	2
BILLBOARD	2	2
PRACTICE	2	2
REACH*	2	2
GANG*	2	2
ADVERTISEMENT*	2	1
HOMO*	2	1
CD	2	1
BUDGET*	2	1
LESBIAN	2	1
TEXT_MESSAGE	2	1
CLUB	1	1
CONFIDENTIALITY	1	1
CHALLENGE*	1	1
COMMERCIAL*	1	1
BULLY*	1	1
DECISION*	1	1
DIED	1	1
FIGHT*	1	1
DVD	1	1
GAP*	1	1
HELPLINE	1	1
I_DON'T_CARE	1	1
KNOWLEDGEABLE	1	1
SPORT	1	1
STD	1	1
STEP*	1	1
STI	1	1

## **Appendix 7- Reflexivity: My role as a researcher**

I am originally from Iran, where I received a bachelor of arts in translation/linguistics studies. While in Iran I worked for the Iranian Academy of Medical Sciences as a research officer and at the United Nation's Population Fund in Tehran where I was involved with different research projects concerning sexual health education and services mostly in remote parts of the country. I audited national sexual health programs commissioned by UNFPA as well. These experiences made me realize how much I like to be involved in sexual health promotion (especially involving young people).

I came to the UK in 2003 to continue my studies, and completed a Master of Science in research methodology. For my dissertation I conducted a systematic review of the literature on technology-assisted sexual health information for high-risk groups of young people in inner city clinics. During my study, I worked part-time for several research projects at Middlesex University and Policy Studies Institute. I also spent one summer as a project officer for Stuart Low Trust (2003), where I interviewed 40 mentally disturbed patients and professionals to develop the case for establishing a 24-hour drop-in service for mentally distressed people. I have also volunteered as a part-time counsellor at Relate, where I received ongoing training in counselling and psychosexual therapy techniques. All of these experiences have provided me with insight into the context in which the sexual and mental health status of young people in England is being developed.

Being a counsellor has helped me to feel comfortable and at ease when communicating with people from all walks of life, including young people. A major part of my training included practising with different types of interactive interviewing techniques, including using open-ended questions in order to get more complete answers from the interviewees and also to help them to clarify the points in their own minds. I

learned to be a vigilant observer, and to interpret emotions and thoughts from reading body language. Finally, I developed some ability to make sense of the hidden meanings in the choice of words and individual uses to express him- or herself. Being a counsellor has raised my respect for and understanding of the importance of confidentiality, and has taught me how to avoid judgement regarding the statements people make. I believe this was very important to this research, as I was able to put young people at ease when sharing their thoughts and experiences.

Soon after I started my research degree, I also attended a session that addressed ‘Training for trainers of sexual health’. This provided me with an insider’s view of the process of designing and delivering sexual health messages. This proved quite useful when interviewing professionals, as I could use their own jargon when interviewing them. Sometimes during the interviews I would find myself sympathising with them, particularly when they shared difficult moments at their jobs. However, as I knew their training material inside out, sometimes I felt they were providing me with the answers that they thought were politically correct or in accordance with the training they received, which made me doubt the data I collected on those specific occasions.

I believe that being an overseas student was advantageous in this research in several ways. First, and perhaps most importantly, I was not seen as an authoritative figure that could not possibly comprehend or sympathise with the social context of someone who had been labelled as “socially excluded”, “marginalised” or “hard to reach”. Instead, young people tended to see me as somebody who does not belong to their social system and is just trying to make sense of it.

Second, young people seemed to trust me easily, which may have been partly due to my ability to identify with them at different levels. Because of my status as an overseas student, I am also, in some ways, an “outsider” although I might not necessarily share the same socioeconomic background as my target group. I could identify with many of the participants as I also felt I had lost some of my extensive social network when I moved to the UK. This helped me to empathise with some of the feelings that young people presented from the perspective of a socially excluded person. I also have a younger sister who was the same age as my research participants when I was doing the interviews. Sometimes I could not stop myself comparing her (from a totally different culture) with my interviewees who mostly were brought up or lived in the UK. This highlighted some of the cultural differences I traced among my respondent group from varying cultures.

Finally, because English is not my mother tongue the process of conducting the interviews, transcribing them, and analysing the data was a relatively big challenge for me. This was exacerbated by the fact that I am used to the academic and formal type of English and sometimes understanding the slang or local dialect (e.g. from East London) of the young people was very difficult. This seeming disadvantage made me more attentive to linguistic details—to the specific words and phrases used by the interviewees. Also, because there were times during the interviewing when I did not understand a word, I had to stop to ask for an explanation. Young people were very patient in their explanations generally, and I interpreted this as a response to my vulnerability. I believe that their perception of my vulnerability encouraged them to be more cooperative, and perhaps to provide more explanations about a topic than they might have otherwise.



## Appendix 8- Sample Interview Transcription and Analysis

### UMI S01

- \*Q: So please tell me a little bit about yourself, where you live and is it a Council house?
- R: I'm living at the Student Hostel at the moment; I'm trying to move out of there, it's a bit hustle. I live at '[...]' Lane, sorry of '[...]' Lane on Lawns Close; I'm twenty, I've lived with myself for the last four years
- \*Q: So you don't share your flat
- R: No
- \*Q: And you said that you are studying, what do you do apart from studying?
- R: Apart from studies I'm hopefully going to start a part-time job as a Security Guard, that's my aim. From there I like coming to, you know take my time, read books, '[...]' and stuff those are my hobbies, listening to music a lot, I like to surf the internet a lot, those kind of things, you know general stuff.
- \*Q: How do you feel about living here, and when you first arrived, can you remember, how did you feel?
- R: Well when I first arrived, at '[...]' I was told I was coming here for a holiday so it was a nice place to come and it was a nice place to see round
- \*Q: So you came here for a holiday
- R: Yeah that's what I have been told when we came by the family, somebody we're only going for a holiday, and then we're going to see your brother, show your brother to the doctors and then we're going to come back for you, which is eleven years I'm doing (broken trust).It's quite nice I mean I love living in London, well not actually in London but part of London, I like the area I mean not in particular where I live but the general area, living in England it's okay but if I, my future plan is to move out because it's I love the place and I do the theory and the stuff but it's just that you get a feeling that you know it's not the thing to live in this country, at the moment I'm enjoying.
- \*Q: Are there any specific problems that you face or
- R: Well, like, any specific problems I have is mainly just the things that go on outside the house, I mean like all these, where I actually live is a really, really dangerous area to live, I mean I've got all these drug users, armed prostitution goes round, and all those kinds of things, uncomfortable to live where I am (immediate environment)
- \*Q: So did you have any problems with these drug abusers around you
- R: You get some, you get some people who hassle you, but it's always to try to talk out of things
- \*Q: So you think that you can forget
- R: Yeah
- \*Q: And do you think that you've settled down here
- R: Yeah I can say that, yeah, I'm feeling this is country now and this country is mine now, just like settle down and enjoy it, don't hold back like I said for the future I've got plans to move either out of London or just move out the country myself (plans for future)
- \*Q: So where do you see yourself in two years from now
- R: Two years now I'll be getting ready to get a good job, that's where I see myself hopefully (vague plans for the future)
- \*Q: And in this country
- R: Yeah
- \*Q: So you want to do work, what about education?
- R: Yes I want to do the education and then see somewhere else to go
- \*Q: Can you tell me a bit about the support that you received when you first came here, who were the people who helped you to settle down here, family, friends, social workers
- R: Well for a short while it was family, and from then on it was the social workers and carers and support units and bits and pieces and all that (immediate circle of support in the past)
- \*Q: Where they helpful?

R: Oh yeah you can say, you can say, I mean not actually get what you're supposed to get at least you get more help than what you get where I came from, so they're okay (attitude towards the system)

\*Q: Okay, so you said that you came here for a holiday

R: Well that's what I've been told (broken trust, note the passive language)

\*Q: With your family

R: But basically when my family did come through they applied for refugee status

\*Q: Ah so you came here as a family

R: Yeah we came here as a family, then I break out with my family

\*Q: But they're still here

R: Yeah they are

\*Q: Right so you have a family here

R: Oh yeah

\*Q: Oh right okay

R: But I don't see them for the last eight or nine years

\*Q: Alright, why was that

R: I had some family difficulties and things happened on the boundaries so I got to move out (lack of family support)

\*Q: Right, do you want to say about that

R: No

\*Q: Okay, at what age did you come

R: The family, I was about around, if I'm not wrong, about round twelve

\*Q: What did you think at the time

R: Well at the time it wasn't easy I mean it wasn't easy to get help, to get placements, but as for breaking out from my family at such a young age wasn't really easy but you get used to it (individual challenges, being let down by the trusted ones)

\*Q: And who helped you

R: I got help from my social services, I got help from '[..]' Child Protection, what do they call them, I forgot the word, you know these people that do child protection work and stuff, mainly I got help from '[...]', they were nice

\*Q: And did you know where to go

R: Well the only place I knew where to go then was my social worker, he took the job on his hand afterwards (his segmented and limited network of support)

\*Q: So you told him that you didn't want to be with my parents or

R: Actually I have been kicked out of the house, because of the way things were going home so (dynamic of the family, leaving care child)

\*Q: And did you receive any support after, you said that you were not religious so you haven't been to one of these religious institutes to get support?

R: No I didn't, never been

\*Q: When you went to ask for help from social workers or after you were separated did you think that they listened to you and actually care and do things for you

R: Not after a certain age, especially as soon as I've been stuck on sixteen I've been left alone and got Benefits and a roof over my head, the rest I done it was all myself, which at the time now I'm learning that on those ages I was supposed to be having a key worker to check over me, make sure I get support to like help with the, you know if I know how to cook, clean, bag it, I mean stay healthy (being let down, ignored and kicked out again, adults who were supposed to take care of him-repetitive pattern as above)

\*Q: So you didn't know that

R: No I didn't get any of those, I couldn't get none of those helps until a certain age were I came to London and learn it but I was too late

\*Q: How did you learn it?

R: Mostly on through rumours like people chatting or reading my, from the leaflets, I never actually got a, send a letter or been informed by the workers that I had

\*Q: But you wished that you had

R: Oh yeah, a bit earlier

- \*Q: When you were separated and you had some questions to ask where did you go?
- R: It was mainly down to social services I would go, I'd go down to social services or friends (network of support in general)
- \*Q: So you had friends
- R: Yeah one or two, people I chat to not really friends but I do (this is the text book definition of a marginalized young person, one or two people is all he knows)
- \*Q: But now you have friends
- R: Oh yeah, yeah, I'm settled I've got my friend, I'm really picky with getting a friend, I mean I like to have a friend that I can learn something from them, I mean what happened, I don't mind teaching what I know but no I was lucky in a way because I really good with my teachers, I'm still in touch with a couple of them, my social workers, so it was nice (does he really have a friend? He seems to be mentioning his teachers and social workers as his friends, is he in touch with these people because he does not know of anyone else his age? Earlier he said he did not think that the system do a good job in informing him about his rights and services, I wonder what makes him them to name people in that system as his friends).
- \*Q: What about your key workers; did you have any key workers
- R: I had zillions believe it or not but most of them just left me after a week, I mean I'd mostly just get a letter that says hi my name is that and that I'm your new key worker or new social worker, and I'll say yea you'll be great and they'd send me an appointment then after, before that appointment times comes I'd get another letter that he'd left or I'd learn it when I go down there that it has been changed (high turn over of the staff in social care services)
- \*Q: How did you feel?
- R: Ah I was really let put down in those days, it was a real let down but I think that's how the system works because mainly, especially the young people that are in Haringey, that works in the Haringey offices there are different barriers they mainly can support themselves for a better education on a different job you get loads of them, you get people that really, really want to work and there are people but not really that often you get those kind of people mainly the people you get from Haringey is, this is my point of view obviously, would suggest that educate themselves forward, which most of my key workers and my social workers have, now one of them is a Police Officer, one of them is a, works for this '[...]' company somewhere because mainly they find themselves that because if they're working in Haringey they weren't getting their education paid and all sorts of stuff that they fund themselves to go forward instead of just staying and doing that work and helping young people (another let down by the adults- the system. The words he uses to describe his feelings towards them is more or less similar to the ones he used towards his family. It seems the pattern is repeating itself and his trust towards the people around him (specially adults) is shaping based on these patterns).
- \*Q: And it is not helpful for young people is it?
- R: Of course there's not because they only get to seem on a part short and especially for young people and that in my situation if you are away from the family and you go that way too far to trust someone, and when you do trust someone and he's let you down it really hurts, it really does leave a mark because what you do who you're trying to trust is a total stranger and they will only stay with you, the only relationship you will have with them or her will be through a work relationship and it's too hard to get trust in them and when you do get let down it's really, really hard, but move on, things are getting much better as far as I heard I mean they are getting more people that needs to help you.(Trust, role of a significant other who is informed and capable of taking them under their wings and help them to find their ways through the system of care).
- \*Q: Are there any other services that you need to help you to be more settled?
- R: Basically I'm sure there is but it's still like I said it's too hard to get moved onto them. I mean when you speak to your social workers and things they say they'll get to you but no there is a few places like there is Connections, there is 4Buses, there's all the sorts of things there like leisure centres, youth clubs for youngsters, there is loads of things but the thing is young

people rarely ask for help and search for themselves (he seems to know of some resources for young people)

\*Q: Where do you go if you need

R: If I need information, I may need like, I just do my one search

\*Q: Where

R: I mean from internet, it depends on the problem I've got, because like housing problem I mainly go down to my housing worker which I only recently knew, her name is Christine I think, but after four years she's been housing worker I only know her name now! So things like housing offices to social offices are always in hand, there are different kinds of teams in the social services buildings, there are care leaders, there are live in care, probation, health, people that live in care team, there are things to help, until you're twenty one you've got help from them. They do allocate you with a housing worker or if you can still able to get help or you get a duty worker to do your work (not hard to reach, he knows where to go to get help for specific everyday needs. They have their segmented network of support but not a conventional one maybe).

\*Q: And, so you told me about how you came to be here, how did you end up in Haringey

R: How did I end up in Haringey, well when we came pass to England we were being settled in a hotel quite near to Stanstead airport in the village, from there on they sent us, from there we moved into London just moved into the Haringey Borough straight, from there we all went to '[...]' and so I've been sent to centre of London, I've been brought back, I've been to '[Newcastle]' so I can't understand why I ended up where I started

\*Q: And now I'm going to ask you some questions about NHS. Have you had any health checks since you came to this country and separated from your family?

R: No

\*Q: No they didn't ask you to do any health checks

R: No, I especially asked myself but I've been informed by my GP, I mean I asked GP to do me one, I got a general check once but

\*Q: When was that?

R: Ages ago

\*Q: Was it the first time that you joined

R: No it was a bit more, afterwards, but I asked for it myself but for a proper health check '[...]'

\*Q: You prefer to go to GP right, so who registered you with this GP

R: Well I've been registered with my GP, my last GP I've been registered myself, before that I was registered by my family so from there on we actually had to change our GP so it's quite a long time with the same GP so I had no problem with that but now recently I've just changed my GP for the last two years, I registered my own self there

\*Q: Why did you change your GP?

R: Well basically it wasn't really good, it was unhelpful, my last GP before the one I've got now actually without you asking he used to do a calculation for you on your medication and why you needed that much, why do you think because the doctor has given it (another adult trying to take charge of his situation but this time he seemed to be able to change the situation with the help of his workers-emphasis on the role of a significant capable adult who can help the young person in need of support).

\*Q: So they didn't really give you information about

R: No

\*Q: Well if you want to talk to me about your GP about then and now, okay, so are the men

R: Mm well it changes, my actual GP under the name I'm signed on is a man, he's called Mr Barnett, I don't really know his first name never did, but when I go down to my GPs I mainly just get seen from women doctor

\*Q: Is it all right for you to be seen by lady doctors

R: Yeah

\*Q: Okay, alright

R: I don't mind

\*Q: And how do you like the change and the quality of GPs, how do you think they can function better

R: No idea, no idea at all

\*Q: You mean no idea

R: I mean no idea at all, I mean you can't complain or do anything, you can complain but I'm not really sure if the complaint form goes and is seen where it's supposed to (mistrust towards the system again-does his opinion matter?)

\*Q: Alright but you were talking about the GP start doing the calculation before he explained it to you

R: I mean that one time, like how do I say this to you, at my GP there was this lady comes and she was, she had a kidney failure and basically the lady was taken for some kind of injection, I don't really know what it's called, it's in her blood and basically when, she normally gets six packets to take to her doctor at the Middlesex, and this gentleman doctor without being asked of him he just sat down, did a calculation for himself and goes down himself and tells the lady why does she used six of them, because six of those injections cost £1000 for the NHS, well basically we said to the doctor why is it, I don't want to be rude but what is it to you, I mean her doctor says you need to get six of these and bring them to me so you give her six of them to take down there, he come across awful, but I mean you do get those kind of people but they're quite rare (throughout the interview he seemed to be grateful and gracious for the services he received even though some had let him down, I wonder is this a pattern for all young people or is this only so because he is an immigrant and has point of comparison?)

\*Q: Alright, so quite positive, okay have you used any other services in the NHS, optician, dentist

R: I do, I've got my dentist and I've got my optician

\*Q: Are the good?

R: Oh yeah they're great, the ones I've got

\*Q: Is it easy for you to go there and access them

R: Mm they are, they're quite helpful especially my optician I mean they even do my forms for me if I need it, I mean they'll say you need to fill a form and I straight away I say oh my handwritings too bad can you do it for me and they go yeah, they're quite helpful they do things, they do let you pay you know like in advance and get your prescription done and then pay it afterwards you know those kinds of things they are optional

\*Q: And who would you talk to if you have any health concerns

R: Who would I talk to if I had any health concerns; mainly it would be my GP or friends that I trusted

\*Q: Can you rely on the information that your friends tell you?

R: No I'd do a research myself and go down to my GP see what he says, and if needed I'll go for a check up

\*Q: Would you go to your GP for the check up

R: Mainly go to my GP or ask him to send me to hospital if I need it

\*Q: Mainly your GP

R: Mainly I'd rely on GP (the first point of contact for many young people seem to be their GPs)

\*Q: Are there any things about health that worries you now

R: No

\*Q: You're okay, so do you arrange for a '[...]' or wait until things come up

R: Mainly wait until things come up, I a bit lazy on that

\*Q: So now I'm starting on sexual health section

R: Yeah sure

\*Q: When you first came here you were eleven,

R: Eleven, no I'm sorry I was nine

\*Q: Nine, eleven years ago

R: I just came, I was just ten when I came here

\*Q: And then when you came here how do feel about the sexual behaviour of the young people in this country

R: Oh my god don't ask me those, oh my god they are so rude, mainly I've been in a couple of children's houses which is like I had a couple of girls and boys you know just running riot and they were doing stuff that I would have been ashamed of, you know what I'm saying, like

- they, like it was a normal thing, I mean I don't know it just depends on people's mentality but there are a lot of youngsters going on, mainly I mean I'm not against the system but I think it's just after a day of sex education there's too much information than we need, because youngsters do attempt to try, I mean I witnessed one of them myself, I mean the school I was going, the man's room I couldn't go into my man's room because it was always packed with two, you know as I say the youngsters will just learn a thing and want to try it out, I think it's just a systems thing giving too much information and it too relaxed, as soon as the youngsters don't get no pregnancy too much they're doing it themselves. I mean if you look at it when they say there's a problem with the youngsters there will be young pregnancy but they don't see the effect on the young age, age is a problem itself, I mean I don't know the system changes it must be from '[...]' I mean I wouldn't do it and I would advise people not do it at such a young age but they have their own choice (cultural element, different attitudes towards sexuality, attitudes towards sexuality education, its format and content)
- \*Q: So you think we are giving them too much information
- R: I do believe that the Government give them too much information than they need, I mean we are, I mean how do I say it, at my time when I used to go to Secondary we used to get a video in and actually see the proper organs of the female or the male in the video and even what happens which they do have in some places, so I do think the information they are getting is too much, you should give them that information, you should tell them what's what and what's to be used for but you know not say like everyday things, you can just do it whatever age you are, they should do bits and soften it up especially for young kids, they should be changing it into like a story thing, I mean I'm not talking bees and honey and stuff but I mean try and be a bit more, not less open but a bit more covered I would say (quality and quantity of sexual health information for different ages)
- \*Q: Oh right, okay, so when you came here you received sex education at school but then you were back home
- R: No where I come from you only know what you got to do on the first night of your marriage which is Dad, this was the eve of your wedding, the girls mum whispers to her, so actually that is stupid I'm really against that I mean you should know what you're doing but you know there should be honour between both of them and not too much information but there should be enough information out there (cultural references, attitudes and methods of provision of sexual health information in different communities. Maybe this could be flagged up as a point to pay attention to by the policy makers and educators in England who deal with ethnic minorities).
- \*Q: Okay and what do you think about contraception
- R: Contraception (experience with SRE)
- \*Q: I mean do you have enough knowledge about contraception
- R: Mm yeah I know how to use my condoms and stuff, I know to keep them safe and everything (confidence towards his knowledge and skills)
- \*Q: Where did you learn this?
- R: Through sex education
- \*Q: So what about your social workers did they talk to you about, teach you anything
- R: No I don't talk to them about that
- \*Q: What do you think about abortions?
- R: It should be done if it's needed, I'm against it if it's just for the sake of getting rid of it for the sake of it, like if it's a dangerous health having a baby for a woman I mean it should be done if it's risking the health of the person it should be done, but not for, oh I made a mistake I'm pregnant and I'm going to get rid of it, no (specific ideas as who should receive SRE, content of the messages)
- \*Q: So what if for example you have a girlfriend and you realise that your girlfriend is pregnant what would you do
- R: Oh if she's pregnant I would like to keep it, but if it's a situation like I said that it's going to damage her health I'm sorry but she's more important to me than the coming baby
- \*Q: So you can see can that abortion
- R: Yeah



\*Q: Where you go to do that

R: Various places, there's always NHS'[...] to get that, or private clinics around

\*Q: Okay so first thing you realise something is happening where do you go

R: Go to your GP (first point of contact, not for information but for help)

\*Q: And what do you think about young people being parents

R: Oh like I said for me, you say you're a child yourself I mean I have seen people and I am seeing people at the age of thirteen, fourteen and they are either pregnant or they already have a baby which is, they don't talk like an adult they're still in a cookie nut themselves

\*Q: Do you think it's more like a girl thing to want a baby or boy thing

R: It's absolutely more like both of them things it's just like two youngsters, it's like trying what they saw on sex education, that's what I'm saying earlier it's like the in thing, I mean these days especially if you're going to a secondary school and you're school ' [...] ' it's like a bad thing next to your friends, it's like not being virgin is a poor thing these days, I don't know, I've never been that lucky I mean ' [...] ' I'm still virgin myself ' [...] ' it's especially hard for the female I mean no fourteen or fifteen year old boy is going to be ready to be a Dad so he's not going to think about the baby, well you shouldn't get pregnant, so it really is a thing, it's supposed to be hard for the parents as well (peer pressure, norms among young people. he is 20 and virgin living within this norm, I wonder if this is because of his marginalized status that he have not had a girlfriend until now, or maybe he does not have the skills and scared to have sex randomly as other young people in the hard to reach category reported).

\*Q: Do you have friends who are young parents

R: Yeah I do I have a couple (young people seem to know at least one people around them who became pregnant or parents while teenagers)

\*Q: Why do you think they have a baby

R; Well actually like I said, when I talk to one of my friends he told me like she had a baby, she was so happy for it they thought instead of her dolls she's now got something real to play with. I mean that's what I'm saying and then she's going all those thinks and aches and pains ' [...] ' because I do have a friend that still gets psychology help about being a parent because I mean it's too hard for a young girl, I'm sure it's hard for every girl to go through all that, I mean I can only presume from the knowledge that I've got, I don't have a chance to go through that thing, I'm sure it's a great painful for older people I mean it should be horrible, terrible for a young person to have a baby, which I especially like a girl explained to me it's like pulling something out of you, just like pulling a part out of you.(his perception of being a teenage parent seemed to be shaped not bt ambitions to get higher education, etc as it is used to discourage young people from becoming parent at younger ages but it is shaped based on his friend experience and his interpretation of their experiences, this should be flagged up in the recommendation section).

\*Q: Okay so you think it happens because they're too young

R: It happens because they're foolish, it's mainly Government fault, I mean sex education these days are too much information, I mean will keep saying that because it is, there is no need especially these video showings of what happens I mean if this stays this flexible I'm telling you young people are going to have a ' [...] ' session at school I mean this is how far it's going, well that's what I think about it(he is blaming the sexual health outcome of young people, mainly teenage pregnancy on the government and the provision of sexual health information (more criticizing the content of it)).

\*Q: And what do you think about same sex relationship since living here

R: That thing goes on, I'm cool with that, everybody's free, everybody's got their own choices and I mainly and strongly that because it always comes out about knowledge or how do I say about things, mainly down to the feelings, if you don't got feelings for a woman and you are a man and you got feelings for a man you can't change that, I mean if that's what you are, that's what you are, it's like being black it's like being white, I mean what you are is what you are, I mean I'm not against that but you know

\*Q: What about in Turkey

R: Oh yeah it's too hard in Turkey about being a gay or as transsexual, it's quite still hard

\*Q: What about abortion

R: Oh yeah there's abortion going, especially if you've got money no one cares, it's always hard for the poor people

\*Q: And if a young person gets pregnant and has a baby

R: I'm telling you in Turkey there's load of young people getting pregnant because in Turkey there is still this mentality that as soon as girl got her boobs she's ready to marry, I'm sorry I'm talking this openly as soon as she's on her period she's ready to get married, it doesn't matter what age she is, I mean she get her period at age of ten that's still (he has a good understanding of the differences between his home country and England and it seems all through the interview that this appreciation has helped him to cope with him problems and keep a rather positive attitude towards the system while criticizing it at times, I wonder if this exists among British young people that I interviewed).

\*Q: If before they get married they are married

R: No it's mainly wed out, if he's on the poor side of the community it's horrible things, especially not just for being pregnant even getting raped is a strong thing to a girl, I mean '[...]' got raped her parents still say it's your fault, I mean how can it be your fault, you've got a girl just been raped by some lunatic, it's just the uneducated part of Turkey

\*Q: And so you haven't talked about your family about I mean to your family about twenty four

R: No, I mean if I need to but like I said to you I've not been able to have good communication relationship with them (lonely young person who is living alone, because he is older than 16 he is not in care either, only had two people to talk to who are his previous social worker and teacher, I still wonder how isolated or hard to reach he is because I was connected to him through his previous social worker, so he was somehow reachable).

\*Q: And who was the person who delivered sex education to you at the school

R: It was our teacher, let me see what was her name, it was a French lady (first experiences with SRE)

\*Q: It's alright I don't need a name

R: It's mainly from the teachers and we kind of like had the sex education in the school

\*Q: You're saying that it's too much information

R: Especially these days yes (quantity of information)

\*Q: How do you think cultural difficulties, is it easy for you to get it

R: Well I've grown up with this culture so it's okay, but I'm still of the culture that I got from Turkey, well actually I grew up in Cyprus, I was born in Turkey but brought up in Cyprus and Cyprus is more like England than Turkey, they're more open, more relaxed, still it was a bit embarrassing, but it was okay

\*Q: So you wouldn't

R: I wouldn't be against it, but I would be against it at the moment it's giving too much (his attitude towards SRE)

\*Q: So you weren't embarrassed at the session because of the culture, I mean culture background

R: Mm I was embarrassed, I didn't know the things so you know, I was embarrassed I mean sometimes it does happen to people you do get, how do I say, what's the word for it, you do, I'm trying to think of the word for it

\*Q: It's alright

R: Your '[...]' do pick up most of the time and that embarrasses you as well and being a '[...]' is really, really hard, no matter what you see and what you get showed and especially the '[...]'

\*Q: Yes I understand, and would you like to receive more sex and relationship education

R: Receive, at the moment no, I mean I'm sure I know pretty much what I need to know (confidence over his knowledge)

\*Q: Okay, and if you wanted to know more information who would you like it to give you

R: Mainly I would be, there's all these different clinics around yeah they do give free sex education and there are brochures, there's always internet or contacts that you can go for, at the moment I don't really know anyone I need to find, but it's quite easy to find one (preferences for the means of delivery and places)



\*Q: Are you familiar with the sexual health services in the area

R: Not really, not really, but I know what to do, there's one at '...' there's always GP, and there's like I said there's a bus goes round 4YP for youngsters, you can always get information from Council buildings (knowledge of services but he has never used them, maybe because he is a virgin and he sees no need to seek information)

\*Q: Okay so '...'needs of young people who come here alone what are the needs that they have

R: Especially for the young people that do come here alone, it's mainly too hard for them especially if they don't know the language, it's mainly what they learn at home among their own people, and I'm talking about older people who come to study or work, or it's they tend to hear from the rumours or through the internet but mainly the main extent of their knowledge of sex is mainly what they learn back home (his description of most vulnerable young people)

\*Q: And what about younger people

R: Younger generation is like here, they mainly know everything like me because it's open, it's like a normal day thing so they've got all these places to find out or (no express of lack of knowledge or need for further information)

\*Q: So if you have any concerns about your sexual health and relationship where would you go

R: Straight to my GP, about relationship, where would I go, I'd mainly go for counselling which should be one of the things

\*Q: Where would you go

R: Relationship counsellors, I don't want to be naughty but they are easy to find, but maybe try to sort them out with your partner, and it is illness the best place is to go down to your GP or one of those centres that do give advice about your status and examines you and stuff

\*Q: And so your life, your everyday life if you want to talk about sexual health who do you talk to

R: If I want to talk about it it would be my friends, it would be someone that I trust, I don't know I wouldn't say, my friends, or my old teachers or my GP (he said he has no friend so in reality it all come down to his GP which is only when he will end up with a problem and will need help not to just go in for further information, he said he won't need any more information).

\*Q: In your view who is the best person to give this information

R: The best person would be a person that has qualification, like a person that does this job like a teacher or a person that works in sexual health department I mean it should be them, not like everyone around you because you do not get the correct information from them, not always (this pattern was seen in young people from similar background as well-Middle eastern or Africans and Muslims. That they preferred a professional to give out the information, I wonder if this is because of the pattern of hierarchy that exists in these cultures as a general rule, also he indicated the reliability of information).

\*Q: And when you wanted to get this information would you prefer to get it in the written form like the leaflets or a CD or DVD or pictures

R: I don't know any of them, mainly brochures

\*Q: Okay, alright and where do you like to get these brochures

R: Like I said from various places, from my GP, you can most of them from the sexual health clinics around

\*Q: I see, and so if you have a girlfriend and you're having sex and you're worried about something you go to whom to check it

R: If you're saying like I said someone that I slept with and I think she wasn't healthy that would be my GP to go and ask him to send me a private clinic to get me straight information from a private clinic so it wouldn't go down on my medical records if I do end up with anything (confidentiality, distrust towards the system)

\*Q: You want him to refer you to a private clinic

R: Because if I go to NHS it would go to my medical record, straight onto my medical record if I do have anything, it would be straight on my medical record

\*Q: And you don't want it

R: Because mainly for particular jobs and places you do have to have a clean medical record sheet and so it does put you down like a freak, I mean those from other countries and are

- dealing with people around but people do not have the situation that you're into it and it's hard for people to understand you, but it does come out that I end up with something then I do take action from it, think is if I don't and it's anything I need to get help with so be it
- \*Q: I see, okay, would you like to add anything
- R: Would I like to add anything, yes, what would I like to add, I would like to add please do give out sex information but not too much for the youngsters especially under sixteen's (provision of SRE, quantity and quality of it).
- \*Q: Okay and the other thing I was going to ask you was how do you think sexual health services can be organised or designed to be more accessible for young people
- R: For young people it would be more, it should be more public, advertised outside, more widely, I mean like Uni Pubs, or schools they should advertise it in those places where you can catch most of the youngsters together
- \*Q: Thanks a lot
- R: No problem
- \*Q: Thank you very much

## **Personal Profile Code: S01**

### *Basic demographics (age, country of origin, religion etc)*

Interviewed in a public place, 20, Turkey, Haringey, English was very good, been here for nearly 11 years.

### *Their story of life*

He came over for a holiday with his parents then they sought asylum and stayed here, later on he had a fight with his parents and left home since 12 then he was with social care, since 16 lived alone in a student hostel.

### *Story of the support they have had*

He came over with his family as a child, so lived with his family for a while, then went to school, then social care and got helps from social services, people dealing with child protection issues and friends. He was given benefits and a place to live after 16 and the rest was up to him, he now realises that he should have had a key worker to help him out in settling down but it is too late now.

### *Main current sources of support*

Friends, not getting along with his family, He thinks that he did not receive the help he wanted but it is better than the country he came from so he feels fine about the supports he received. He was very clearly mentioned that his trust has been jeopardized because of the turn over of key workers. He also mentioned that it is just the matter of educating themselves and move one without paying attention to the people like who really trusted them and need their helps. Because Haringey will pay for their education.

### *How do they feel about living there environment?*

Feel fine, but the area he is living is not safe and he has been approached by drug dealers and prostitutes. Wants to be a security guard. I want to move out London or the country in the future. He settle he is settle down. He is aware of some services available like leaving care team, youth clubs, connexion, 4 YP buses, etc, but believes that this is difficult to move on to them if has a problem.

### *General Health*

He feels fine

### *Views on, and experiences of, the sexual/health services*

Just had a general check once. He asked for it himself.

### *Contact with GP*

Registered with family first, but then registered by him. Changed his GP, because he was not helpful. He was just giving him drugs with no information. It is a lady and he does not mind her gender. He thinks if you complain it might not get further than receptionist.

### **Sexual health**

#### *Views on sexual behaviour in UK (and country of origin or their community if relevant)*

They are so rude, young people at my age them want to do0 things that he is ashamed of it.

### *Experience of sex and relationships education*

Embarrassed at the sex education session at school. He thinks sex education is too much because he saw at men's room at school, young people wanted to try out things they have been taught. He thinks having sex this young is wrong but they only focusing on young people getting pregnant. In Turkey people will learn about it just when they got married, their parents whisperer it to their ears. He thinks people should be eructated but not that much. Homosexuality is hard in back home. In Turkey girls get married as soon as they get their period. If a girl get rape, they would tell her this was your fault if they are from poor side of Turkey.

### *Level of sexual health knowledge (e.g. how you get pregnant, STIs , contraception, services?)*

Knows about condoms, services.

### *Sexual behaviour*

He did not have a sexual relationship yet. If pregnancy becomes dangerous for the woman or the baby he thinks abortion can be done (in private clinics or GPs), He thinks it is sick to have a baby while you are a baby yourself. He thinks not being a virgin is a cool thing. But he is proud of being a virgin.

He thinks young mothers like to play with their babies like a dull. He has friends who still getting mental health support after becoming young parents, because it is painful and it is worst for younger person. It happens because young people are foolish in his idea. Being homosexual is being like black or white I am not against it.

### *Sexual health needs (including own sexual health, and views on needs peers)*

He would go friends, someone whom he trusts, old teachers, GPs, he likes to be referred to a private clinic. He won't like to go to NHS because it will appear on his medical record and can affect his future employment.

Goes to GP, then does his search if had any questions.

*Views on how sexual health services and sex education programmes could be developed (including views on how would like to receive information)*

He thinks if there are more advertisements, in public places like universities, etc, will help informing young people. Brochures are good source of information in his opinion. Like to collect them from GP, sexual health services. He thinks they should not give information to young people especially for under 16s. a person who is in sexual health profession should provide it because then the information will be correct.

## Main themes

Descriptive	Interpretive
Trust	Mistrust towards the system, adults while trying to keep positive because he has a more negative point of reference from his home country.
Need for help at different phases of his life	Need for a capable, informative adult who cares to certain extent, even a person who does this caring as a job will be effective  Seeking help rather than information
Embarrassment	Being let down is a pattern in his life, he has found a way to cope with it.
Confidentiality	Sexual activity is not on the front of his mind, he wants to find a job
GP as the first source of help for health problems including sexual problem	
Quantity and quality of sexual health information is "not good, too much"	
Confidence over his SH knowledge	
Reliability of information	

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